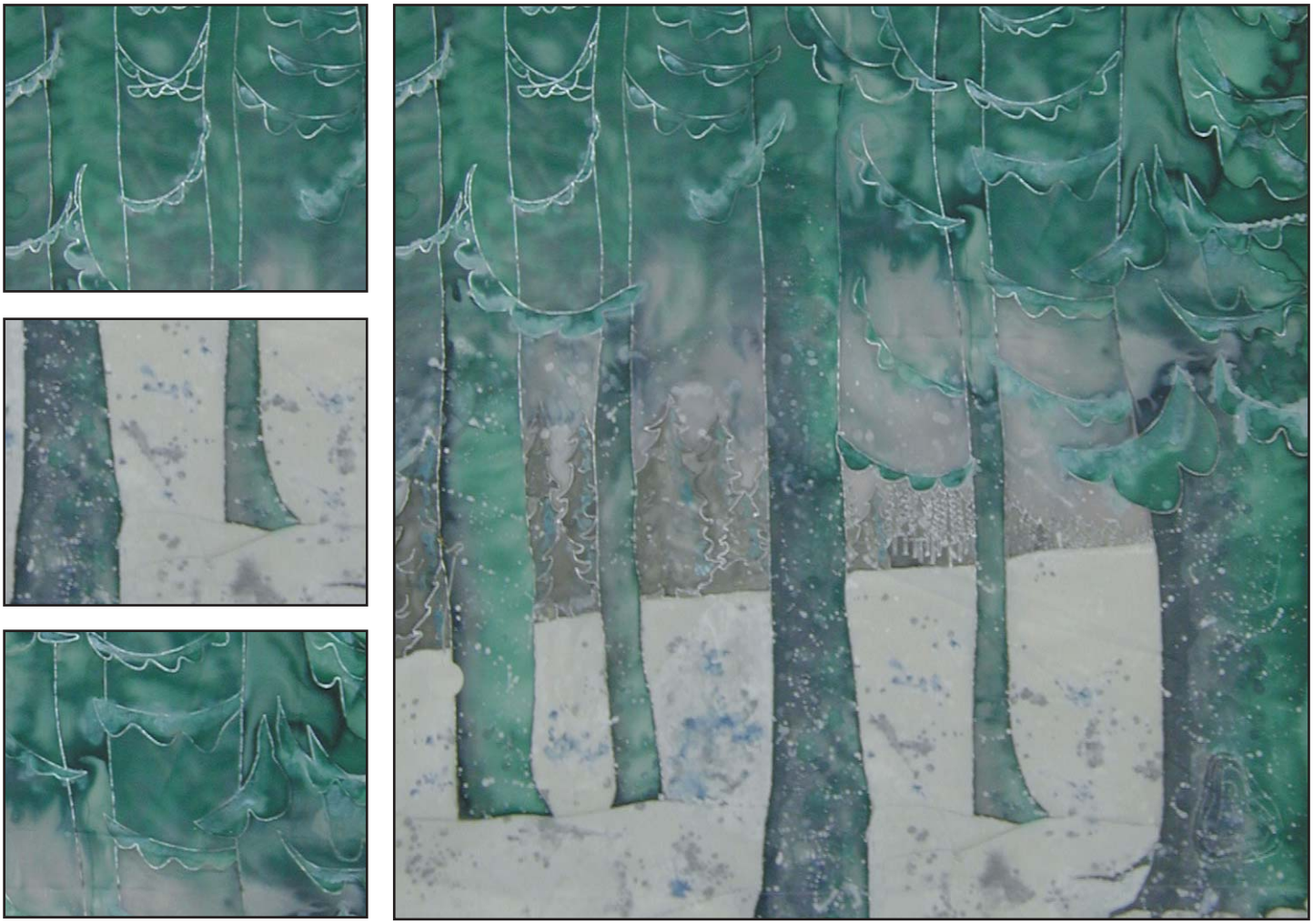
NHS

*National Institute for Mental Health in England*

# Cases for Change

## Policy Context



mental health questions? **ask NIMHE**

## Cases for Change

Mental health services in England are experiencing a period of unprecedented change. The pace of this change is potentially matched only by the pace at which information about both effective and less effective practice in mental health care is emerging. Over the past five years an incredible wealth of published literature has continued to remind all those engaged in developing mental health services of the reasons why fundamental change is necessary and of how services might be improved to better meet the needs of service users.

In addition to the evidence emerging from the research literature, it is important to recognise the role that publications appearing beyond the peer-reviewed journals have also had in informing the many cases for change that exist in adult mental health care today. These include publications reporting non-research based service reviews and the expert opinion of groups and organisations representing the interests of mental health service users, carers and professionals.

For those engaged daily in supporting change in local mental health services it can be difficult to feel well informed of the context of evidence and opinion within which current mental health policy has been established. With this in mind, in late 2001 the National Institute for Mental Health in England (NIMHE) commissioned a review of recent literature on adult mental health services with a view to producing an accessible summary of the emerging cases for change.

Cases for Change comprises ten booklets.

- **Introduction:** describes the background and methodology of the review and also summarises the findings and suggests areas for future research/policy development.
- **Policy Context:** describes the context of the review with an overview of recent mental health policy.

The following seven booklets each consider a different aspect of mental health service provision:

- **Primary Care**
- **Community Services**
- **Hospital Services**
- **Forensic Mental Health Services**
- **Partnership Working Across Health & Social Care**
- **User Involvement**
- **Anti-discriminatory Practice**
- **Emerging Areas of Service Provision:** reviews the literature that does not fit neatly into any of the previous topics.

The review collates evidence from over 650 documents published between January 1997 and February 2002 concerning adult mental health service delivery and/or policy in England. With the information collected synthesised into a number of key themes or issues, the review aims to describe how we got to where we are today and sets out the cases for change from the evidence base.

The articles highlighted at the beginning of each booklet as The Nature of the Evidence are those that are particularly relevant to the cases for change cited in the booklet concerned. Each document within the review has been classified using the "hierarchy of evidence" adopted in the *National Service Framework for Mental Health (NSF)* (Department of Health, 1999a):

- Type 1 evidence represents at least one good systematic review, including at least one randomised controlled trial.
- Type 2 evidence represents at least one good randomised controlled trial.
- Type 3 evidence represents at least one well-designed intervention study without randomisation.
- Type 4 evidence represents at least one well-designed observational study.
- Type 5 evidence represents expert opinion, including the opinion of services users and carers.

At the end of each of the main booklets, there are critical commentaries by service users and practitioners/managers/policy analysts from across England. These commentaries are intended to emphasise that different groups of people have different priorities and identify different cases for change. All contributors have been encouraged to be as challenging as possible and, where they disagree with interpretations, to say so.

Each booklet can be read independently or alongside one another to bring together a full picture of the development of mental health services. We hope this will be helpful in enhancing our understanding of the history as well as emphasising the need to develop future individual services within the context of an integrated system of care and support.

Cases for Change should be seen as a starting point and as a means to an end rather than an end in itself. By summarising the key issues that have emerged from the literature and by emphasising the diversity of opinion that exists within mental health services, Cases for Change may help to encourage debate about the best way forward and the way in which different view points can be balanced to achieve mutually beneficial outcomes.

Cases for Change has been written by a multi-disciplinary research team based at the University of Birmingham with the active support and encouragement of Susannah Rix at NIMHE Eastern, the guidance of the Expert Panel, and service users and practitioners who have provided written commentaries for the main sections of the review. Our thanks also to colleagues in the mental health group at the Department of Health for their editorial input to help finalise the publication.

The research team comprised:

- Jon Glasby, a qualified social worker and a lecturer at the Health Services Management Centre.
- Helen Lester, a GP, national primary care career scientist and Co-Director of the University of Birmingham's Interdisciplinary Centre for Mental Health.
- James Briscoe, a consultant psychiatrist and senior lecturer in the University of Birmingham's Department of Primary Care.
- Marion Clark, a former teacher who worked on this study as a user consultant.
- Steve Rose, Library and Information Services Manager at the Health Services Management Centre at the time of this review and now Health Care Libraries Manager, University of Oxford.
- Liz England, a clinical research fellow in the University of Birmingham's Department of Primary Care.

## Four Seasons

These original artworks were designed and painted by a team at The Hollies in Ipswich, Suffolk. Working together the group generates ideas, energy and input. The community spirit engendered provides a platform that allows creativity to shine through. The group experience builds confidence and develops a sense of esteem. *"This kind of work may not cure our problems, but this is the first year I have not been admitted to hospital".*

The Hollies is a Social Enterprise developing meaningful work opportunities for people who have used mental health services. Social Enterprise can and does create real jobs. The pictures illustrate a theme of constant change and renewal in nature. They reflect the changes that can evolve through Social Enterprise and working together.

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# Policy Context

This booklet aims to provide the context for the policies and practices described in the review. Specifically it will provide an overview of recent mental health policy including policy documents published during the writing of the review (January to November 2002), identifying key themes and challenge that have guided thinking and policy responses.

The term 'mental health policy' at the beginning of the 21st century encompasses a wide range of issues including:

- Management of symptoms of mental ill health.
- The promotion of well being.
- Risk and vulnerability.
- Constructing effective services.

Given such a wide remit, it is difficult to trace a neat chronology of ideas in mental health theory, policy or practice. As Prior (1993) warns:

*"The history of 20th century psychiatry does not lend itself to the drawing of simple divisions, nor to the display of any easily readable trends away from one set of objects and locations and towards another."*

Therefore in describing the history of recent mental health policy, a number of key issues highlighted by the Cases for Change literature have been used as a Framework:

- The development of community based services.
- Balancing issues of risk and vulnerability in the community.
- The move towards more accountable care in the NHS.
- The increasing role of primary care in delivering good quality mental health services.
- User involvement and inclusion agenda.

A strictly chronological approach to documents related to mental health (which may be useful for those with new mental health responsibilities) is provided at the end of this booklet.

### The development of community based services:

De-institutionalisation has been a recurring theme in many countries throughout the latter half of the twentieth century. In 1954 there were 154,000 residents in UK mental hospitals. By 1992 this figure had fallen to 50,000 (Rogers and Pilgrim, 2001).

**Figure 1 Better Services for the Mentally Ill**

**In the introduction to the White Paper, Barbara Castle wrote (Department of Health and Social Security, 1975, pp.2-3):**

*"Mental illness is a major health problem, perhaps the major health problem of our time. It is also a major social problem…By far the great majority of people are never referred beyond primary care to the specialist psychiatric services…What we have to do is get to grips with shifting the emphasis to community care. The problems are many. Social services facilities have to be built up…Staff to run them have to be recruited and trained…Psychiatric services have to be developed locally, in general and community hospitals and in health centres. We have to recognise, moreover, that the pace at which community based care can be introduced depends not only on resources but on the pace of response of the community itself…Local services mean more day hospital treatment, more day care, more treatment and support in the home itself and less in-patient treatment…The policy can only be achieved if there is substantial capital investment in new facilities and if there is a significant shift in the balance of services between health and the local authority."*

In 1975, when there were 100,000 people in UK mental hospitals, *Better Services for the Mentally Ill* set out norms that later became guidelines for future community mental health services. It was explicit in stating that developing community care would be a long-term programme requiring significant financial investment (see figure 1).

It is interesting to reflect that the ideas enshrined in the *National Service Framework for Mental Health* (Department of Health, 1999a) and other recent mental health policy guidance were rehearsed in this way 25 years ago, highlighting the importance of active government leadership and facilitating change.

By 1986, although 80 to 90% of people with mental health problems were living in the community, more than 80% of available resources were and indeed still are being spent in the hospital sector, which helped persuade the Government to ask Roy Griffiths to produce recommendations for the future of community care. *The Griffiths Report* (1988) raised concerns about the resourcing of community care and also recommended that in order to reduce potential confusion between agencies, local authority social services department should be given the lead role in the provision of community care.

Griffiths' proposals were enshrined in the White Paper *Caring for People* (Department of Health, 1989) and the *NHS and Community Care Act 1990.* The latter introduced the following important changes:

- A distinction between purchasing and providing functions.
- A requirement for local community care plans.
- The creation of provider trusts and fund-holding general practices.
- The transfer of funds for residential care from the Department of Social Security to social services.

However, problems soon became apparent including inefficient interagency collaboration, particularly where different parts of the system (the NHS, social services, the voluntary and private sectors) had different ideologies and priorities (Bean and Mounser, 1993). Mechanisms for effecting the shift of finance from hospitals to community care were also often challenging to implement. Fear of innovation and failure and an attachment to traditional working practices on the part of planners and providers also created barriers in terms of change (Hayes, 1998).

### Balancing issues of risk and vulnerability in the community:

A number of different measures were introduced during the 1990s to try and balance the issues of risk and vulnerability in the community. The Care Programme Approach (CPA) introduced in 1991, required that everyone seen by specialist mental health services should have their need for treatment assessed, a care plan drawn up and a named mental health worker to co-ordinate their care, including a regular review of their needs. The CPA aimed to help provide continuity of care across different services, promote multi-professional and agency working, and ensure appropriate care for people diagnosed with serious mental illness on discharge from hospital.

In April 1994, supervision registers were introduced for particularly vulnerable people

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to identify, provide information and care for service users "who are liable to be at risk of committing serious violence or suicide or serious self neglect" (NHSE, 1994, p.1).

Difficulties in using the register in practice and inconsistencies in use between Trusts (Bindman et al., 2000) led to a simplified two-tier CPA (of which risk assessment is an ongoing and essential feature) which is now in place (Department of Health, 1999b).

The importance of public safety was also prominent in the introduction of the *Mental Health (Patients in the Community) Act 1995*, which made provision for the supervised discharge of mentally ill people in the community. Supervised Discharge Orders (SDOs) allowed clinicians to specify where patients should live, to require them to attend for treatment and to require that they allow access to members of a clinical team for the purpose of assessment. They did not include the power to enforce medication in the community. As with supervision registers, evidence suggests that SDOs are rarely used and that their effectiveness is limited by their variable application (Pinfold et al., 2001).

In July 1998, Frank Dobson, the then Secretary of State for Health argued that (Department of Health, 1998d), "*Care in the community has failed. Discharging people from institutions has brought benefits to some, but it has left many vulnerable patients trying to cope on their own. Others have been left to become a danger to themselves and a nuisance to others. Too many confused and sick people have been left wandering the streets and sleeping rough. A small but significant minority have become a danger to the public as well as themselves.*"

Judy Clements from Mind challenged this argument, suggesting that community care had not so much failed as never really been tried (Clements, 1998, p.19):

*"We believe this view overlooks the many thousands discharged from the old hospitals for whom community care has been a resounding success. Taken alone, it [the statement] may suggest that somehow it is wrong for people with mental health problems to be in the community and add to the stigma and discrimination for this already excluded group."*

The publication of the White Paper *Modernising Mental Health Services: Safe Sound and Supportive* (Department of Health, 1998a), highlighted core priorities including:

- Strengthening comprehensive care (with considerable emphasis on gaps in current services, particularly those affecting services for people with severe mental illness).
- The provision of beds (particularly acute beds), including 24 hour nursed care and secure beds.
- Assertive Outreach teams.
- Crisis Intervention teams.

Continuing tensions around "care or control" in the community were again highlighted the following year with the publication of a series of papers and consultation documents on the revision of the Mental Health Act 1983.

Since the Richardson Committee made its recommendations three years ago, there has been a green paper (Department of Health, 1999f), a white paper (Department of Health, 2001c,d) and a draft Bill (TSO, 2002), consultations and a Road Show.

Much has changed since mental health legislation was last passed: patterns in care and treatment, with an increasing emphasis on supporting people in the community, and international human rights law, brought into statute in the late 1990s. The proposed legislation introduces some significant new protections for people compelled to comply with treatment: independent advocacy, an independent Tribunal system, greater freedom in deciding a nominated person and an individual care plan.

The consultation to the draft Bill produced nearly 2,000 responses. These made helpful suggestions and observations. The Bill is now being refined and completed, in light of the consultation, to ensure that it achieves its intended effect. The Bill will be introduced as soon as parliamentary time allows. Ultimately, in proposing legislation to parliament, the Government will need to mediate between a number of different perspectives (see, for example figure 2 and Grounds, 2001; Birmingham, 2002) including:

- The rights of the individual with a mental disorder.
- The responsibility of the state to act paternalistically in the interests of the individual when mental disorder prevents them from doing so.
- The need to minimise the risk of danger to others.
- The duty to take account of the voice of the victim.
- The roles of different professional groups.

### The move towards more accountable care in the NHS:

Since 1997, the government has set out a number of interlocking pieces of policy which together aim to increase accountability across the health and social care sector and improve the quality of health services.

The policy pronouncements on accountability in service development and delivery were also echoed by fundamental reforms of medical practice and performance, including mechanisms and procedures to ensure standards of competence, care and conduct and the introduction of compulsory appraisal and revalidation procedures for the medical profession (General Medical Council, 1998, 1999). Key government policy documents include:

1. *A First Class Service* (Department of Health, 1998b) the driver of clinical governance. First published in 1998, it put forward a tri-partite rationale consisting of:

- A system of standard setting across the NHS (e.g. the National Institute for

**Figure 2 Risk and Vulnerability**

**William Bingley, for example, commenting on the Review of the Mental Health Act 1983 at the Select Committee Hearing on Health in 1999 emphasised that while public risk has to be safeguarded, it should not be seen as the focus of mental health legislation and that best practice requires a balance:**

*"I do not think that one can ignore public safety. It has always been a legitimate concern in all mental health legislation. When you are talking essentially about therapeutic coercion, which I suppose is what lies at the centre of mental health legislation, I think it is a question of balance… it is a question of getting it right and making the predominant core value of any future legislation about health, about adding benefit to peoples' health and that essentially it is a therapeutic exercise."*

**(Bingley, Select Committee on Health 4th report, 2000, p.277)**

Clinical Excellence and National Service Frameworks).
- A delivery system of quality standards through clinical governance, life long learning and rigorous professional self-regulation.
- A monitoring system through the Commission for Health Improvement, the National Performance Assessment Framework and the national survey of patient and user experience.

2. *The NSF for Mental Health* (Department of Health, 1990a), a 10-year programme published in September 1999, which focuses on adults with mental health problems aged between 18 and 65 years of age. The NSF contains seven standards that address different aspects of care and milestones and performance indicators relating both to individual practice and to service organisation and care delivery (see figure 3).

The aims of the NSF standards are:

- Mental health promotion - to ensure health and social services promote mental health and reduce discrimination and social exclusion associated with mental health problems.
- Primary care and access to services - to deliver better primary mental health care, and to ensure consistent advice and help for people with mental health needs, including primary care services for individuals with severe mental illness.
- Effective services for people with severe mental illness - to ensure that each person with severe mental illness receives the range of mental health services they need; that crises are anticipated or prevented where possible; to ensure prompt and effective help if a crisis does occur, and timely access to an appropriate and safe mental health place or hospital bed, as close to home as possible.
- Caring about carers - to ensure health and social services assess the needs of carers who provide regular and substantial care for those with severe mental illness and provide care to meet their needs.
- Preventing suicide - to ensure that health and social services play their full part in reducing the suicide rate by at least one fifth by 2010.

3. The *NHS Plan* (Department of Health, 2000d) which outlines an ambitious vision of changes over ten years in service delivery, workforce and priorities including:

- 1,000 new graduate mental health staff to work in primary care.
- An extra 500 community mental health team workers.
- 50 early intervention teams to provide

**Figure 3 The National Service Framework for Mental Health**

The NSF has seven standards (Department of Health, 1999a):

*Standard one*

Health and social services should:
- Promote mental health for all, working with individuals and communities.
- Combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

*Standard two*

Any service user who contacts their primary health care team with a common mental health problem should:
- Have their mental health needs identified and assessed.
- Be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.

*Standard three*

Any individual with a common mental health problem should:
- Be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care.
- Be able to use NHS Direct, as it develops, for first-level advice and referral on to specialist helplines or to local services.

*Standard four*

All mental health service users on CPA should:
- Receive care which optimises engagement, anticipates or prevents a crisis, and reduces risk.
- Have a copy of a written care plan which includes the action to be taken in a crisis by the service user, their carer, and their care co-ordinator, advises their GP how they should respond if the service user needs additional help, is regularly reviewed by their care co-ordinator.
- Be able to access services 24 hours a day, 365 days a year.

*Standard five*

Each service user who is assessed as requiring a period of care away from their home should have:
- Timely access to an appropriate hospital bed or alternative bed or place, which is, in the least restrictive environment consistent with the need to protect them and the public as close to home as possible.
- A copy of a written after care plan agreed on discharge which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis.

*Standard six*

All individuals who provide regular and substantial care for a person on CPA should:
- Have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis.
- Have their own written care plan which is given to them and implemented in discussion with them.

*Standard seven*

Local health and social care communities should prevent suicides by:
- Support local prison staff in preventing suicides among prisoners.
- Ensure that staff are competent to assess the risk of suicide among individuals at greatest risk.
- Develop local systems for suicide audit to learn lessons and take any necessary action.

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**Figure 4 Living with a common mental illness**

Rachel Jenkins et al (1998) suggests there is a strong argument that the consequences of common mental health problems are themselves cumulatively significant on many levels:

*"It is no longer tenable to argue that this burden of the common mental disorder should be ignored – the costs of so doing are immense in terms of repeated GP consultations..., sickness absence …, labour turnover…, reduced productivity, impact on families and children and the more difficult to quantify but none the less important concept of the emotional well-being of the country and nation."*

**(Jenkins et al., 1998, p.138)**

The nature of mental illness may also be intermittent and episodic, and it is not always helpful to attempt to place individuals in fixed categories. As a witness to the House of Commons Health Committee observed:

*"I think it is a dangerous road to go down if we start labelling people as severely mentally ill or just the worried-well, because I have been both, and I have been both on the same day."*

**(Tony Russell, cited in House of Commons Health Committee, 2000, p.xviii)**

treatment and support to young people with psychosis.
- 335 crisis resolution teams.
- An increase to 220 assertive outreach teams.
- Women only day services.
- 700 extra staff to work with carers.
- More suitable accommodation for up to 400 people currently in high secure hospitals.
- Better services for prisoners with mental illness.
- A care plan and key worker for every prisoner leaving prison with serious mental illness.

4. *The Mental Health Policy Implementation Guide* (Department of Health, 2001h) which was brought out to support the implementation of ideas outlined in the *NHS Plan* and *NSF for Mental Health*. It provides detailed descriptions of service models for the key elements of the mental health service. The Guide encourages a "whole systems" approach (p.8):

*"that goes beyond ensuring the inclusion of the full range of agencies and services. It also means looking within services to the underpinning systems and strategies and ensuring that they support the new pattern of services... New ways of working are required, and services must ensure that sufficient staff with the right range of competencies can be recruited and retained."*

The Guide is not a prescription, and is meant to encourage rather than suppress local creativity, so that while certain services models are specified, there is also an emphasis on tailoring services to meet local needs. Engaging all local stakeholders in planning change is also emphasised. Initial guidance included advice on:

- Crisis Resolution.
- Assertive Outreach.
- Early Intervention.
- Primary Care.
- Mental Health Promotion.

Recent guidance has provided ideas and information on:

- Adult Acute Inpatient Care Provision (Department of Health, 2002e).
- Dual Diagnosis Good Practice (Department of Health, 2002f).
- Community Mental Health teams (Department of Health, 2002g).

### The increasing role of primary care in delivering good quality mental health services:

The publication of *The New NHS: Modern, Dependable* (Department of Health, 1997) formally announced the demise of GP fund holding and the internal market. It placed an emphasis on a renewed commitment to equity of access and provision and tackled the need to ensure quality through clinical governance and accountability to local communities. The major structural change introduced to deliver these policy goals was the formation of Primary Care Groups (PCGs) with the expectations that they would mature to Primary Care Trusts (PCTs).

Following a period of consultation, shadow PCT boards were established in September 1998, and in April 1999, 481 PCGs were established throughout England. Seventeen of these formed the first wave of PCTs a year later. The *NHS Plan* (Department of Health, 2000d) stated that all PCGs would become PCTs by April 2004, and *Shifting the Balance of Power* (Department of Health, 2001n) accelerated this timeframe. PCTs were acknowledged as the leading NHS organisation for partnership with Local Authorities, and a range of other partners, including NHS Trusts, Strategic Health Authorities, other PCTs and local communities and were expected to take responsibility for securing the provision of a range of services for the local population. In *Shifting the Balance of Power - the next steps* (Department of Health, 2002c), published in January 2002, PCTs were specifically given responsibility for commissioning all mental health services. This increase in the rate and pace of change is also evident in other areas of health and social care (Glasby and Littlechild, 2000) and can be seen in more detail in the chronology provided at the end of this booklet.

The advent of PCTs' commissioning powers suggests that a number of issues will need debating at both a local and national level to ensure that all mental health services users receive good quality equitable care. For example, there is a need for PCTs and their health and social care partners to agree on their definition of "common" and "serious" mental illness (see figure 4) whilst bearing in mind an evidence base that suggests the consequences of common mental health problems can be considerable both at an individual and societal level (Jenkins, 1998).

Many PCTs are also still in the process of developing an understanding and appropriate level of skill in key areas including commissioning appropriate user-centred mental health services (Lester and Sorohan, 2002). There are a number of inititiaves that have been put in place to help guide PCTs in their extended roles in mental health. In addition to the relatively new National Institute for Mental Health in England (NIMHE), the leadership centre, part of the Modernisation Agency has a programme specifically tasked with developing knowledge, skills, attitudes and vision of new PCT leaders. The National Primary and Care Trust Development Programme (www.natpact.nhs.uk) created in the Summer of 2001 following the publication of *Shifting the Balance of Power*, has also been tasked with

establishing a programme of organisational and personal development to support PCTs and Care Trusts to deliver on their core functions, including commissioning.

**User involvement and inclusion agenda:**

Policies addressing issues of social exclusion and increasing user involvement in services have particular resonance for mental health service users:

*"Unemployment, social isolation,…stigma, contempt and fear surround people with mental health problems like a shroud. It is easier to live in society with a prison record that with a psychiatric record."*
(Witness to the Mind inquiry into social exclusion, cited in Dunn, 1999)

People with mental health problems experience very high rates of unemployment which adds to the cycle of poverty and social exclusion. Access to employment and education for users with mental health problems is therefore particularly important.

Supporting policies include:

1. *The Disability Discrimination Act 1995*, which was the first attempt by a British government to legislate against the discrimination faced by disabled people. The employment provisions in particular marked an important step forward by providing disabled people with significant rights. A Disability Rights Taskforce, set up to advise the government on what further action was needed, convened the Disability Rights Commission which provides both a mechanism for disabled people to assert their rights and an opportunity to work with employers to ensure equal treatment for disabled people.

2. *Welfare to Work*, the government's overall policy framework and programme for reform of the welfare state, which includes the New Deal for Disabled People (NDDP) which addresses the needs of mental health services users. The NDDP recognises the particular barriers to employment and education faced by this group in society, and includes new advisory services and a limited range of more intensive support aimed at enabling people claiming disability benefits to return to work. The NDDP was implemented nationally in April 2002. Such measures will need to be strengthened and built on to help enable users to lead inclusive lives. These issues are discussed in greater detail in the booklet on User Involvement.

3. The government's current emphasis on user and public involvement in decision-making processes in all parts of the health service builds on over a decade of policy pronouncements in this area. According to the Department of Health, the involvement of the public and service users in the NHS will produce the following benefits (Department of Health, 1998c, p.26):

- Contribute towards accountability.
- Develop a greater local understanding of issues.
- Strengthen public confidence and a sense of ownership.
- Lead to more responsive services.
- Challenge any paternalistic models of service provision.

In July 2000 the *NHS Plan* (Department of Health, 2000d) set out a statutory duty for the NHS to involve and consult the public when planning or changing services, and this was subsequently enshrined in the *Health and Social Care Act 2001*. Most recently, the *NHS Reform and Health Care Professionals Act 2002* effected the following changes in user involvement in health care in general:

- The establishment of patients forums in all Trusts.
- The setting up of a commission for patient and public involvement in health.
- The establishment of independent complaints advisory services.
- The abolition of community health councils.

The significant reorganisation of the health service following *Shifting the Balance of Power* (Department of Health, 2001n) may also mean that new organisations prioritise basic issues such as staffing and information technology infrastructure and have less capacity and capability to implement policy guidance on user involvement. Evidence to date certainly suggests it may slip down the list of PCT priorities in the short to medium term (Anderson and Florin, 2000; Shepherd, 2000). These issues are discussed in more detail in the booklet on User Involvement.

## Further information

For those wishing to explore the mental health policy context in more detail, there are a number of introductory textbooks available (see, for example, Coppock and Hopton, 2000; Rogers and Pilgrim, 2001).

Details of government policy documents are available on their mental health website (www.doh.gov.uk/mentalhealth/atozpubs.htm) while relevant statutes can be viewed on the HMSO website (www.hmso.gov.uk) together with detailed explanatory notes. One of the key questions that emerged from this review is how best to introduce effective change. Service users, practitioners, managers and policy makers have not only to consider what changes they need to make, but also how to ensure that such changes are implemented effectively and imprint on the fabric of their services. To do this, they will need to draw on key lessons from the literature on innovation and on change management. While it is beyond the scope of this review to explore this literature in detail, there are some important basic principles that organisations need to be aware of when trying to implement change:

- Key features that organisations need to take into account to effect and manage change are described in Kanter et al's (1992) The Challenge of Organisational Change.
- A comprehensive guide to managing change in the NHS produced by the SDO (Iles and Sutherland, 2001) can be downloaded free of charge from www.sdo.lshtm.ac.uk/publications.htm.
- Getting Better Together, information about the Mental Health Collaborative that involved a methodology for bringing about change by supporting clinical teams to try out small changes to improve services, can be downloaded from the Northern Centre for Mental Health (www.ncmh.org.uk).
- NIMHE intends to undertake a literature review of implementation of change to help inform thinking and work to support the changes in practice.

# Policy Context

## A Summary of Policy Relevant to Mental Health 1975-2002

| | |
|---|---|
| 1975 | *Better Services for the Mentally Ill* published |
| 1986 | *Making a Reality of Community Care* published |
| 1988 | *Griffiths Report* published |
| 1989 | *Caring for People* published |
| 1990 | *NHS and Community Care Act* passed |
| 1991 | Care Programme Approach (CPA) introduced |
| 1994 | *Health of the Nation* published |
| 1994 | *Ritchie Report* published |
| 1994 | Supervision registers introduced |
| 1995 | *Disability Discrimination Act* passed |
| 1995 | *Mental Health (Patients in the Community Act)* passed |
| April 1997 | *National Health Service (Primary Care) Act* passed |
| December 1997 | *The New NHS: Modern, Dependable* published |
| June 1998 | *A First Class Service* published |
| December 1998 | *Modernising Mental Health Services: Safe, Sound and Supportive* published |
| April 1999 | 481 PCGs go live |
| April 1999 | *The Health Act* passed |
| October 1999 | *National Service Framework for Mental Health* published |
| November 1999 | *Richardson Report* and Green Paper on reforming the Mental Health Act published |
| February 2000 | Commission for Health Improvement established |
| April 2000 | 17 first wave PCTs go live |
| July 2000 | *The NHS Plan* published |
| October 2000 | Human Rights Act 1998 came into effect |
| March 2001 | National Mental Health Information Strategy launched |
| March 2001 | Mental Health Policy Implementation Guide published |
| April 2001 | Modernisation Agency launched |
| July 2001 | *Shifting the Balance of Power* published |
| July 2001 | National Institute for Mental Health (England) (NIMHe) guidance document published |
| August 2001 | *Health and Social Care Act* passed |
| August 2001 | Workforce Planning, Education and Training Programme in Adult Mental Health Services published |
| January 2002 | *Shifting the Balance of Power – the Next Steps* published |
| April 2002 | New Deal for Disabled People is extended nationally |
| April 2002 | PCTs go live across England |
| June 2002 | *NHS Reform and Health Care Professionals Act* passed |
| June 2002 | Draft Mental Health Bill published |
| June 2002 | Launch of NIMHE |

## References


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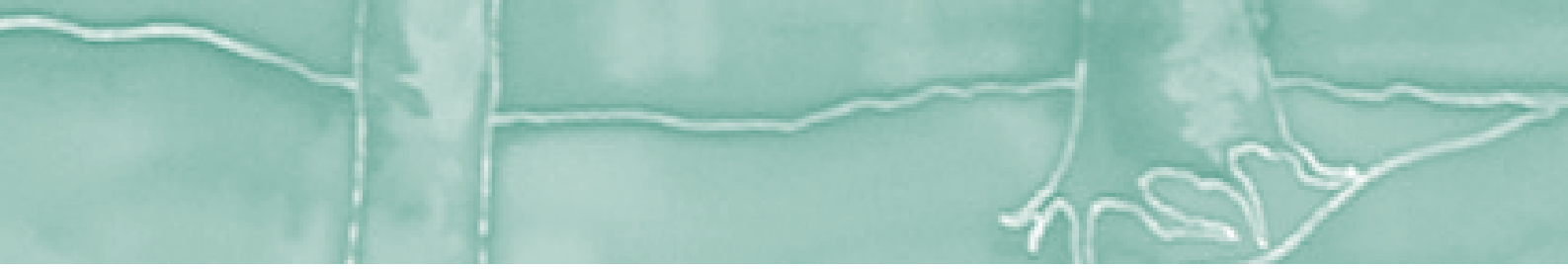
# Policy Context



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