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Policy and Agency Contexts

National occupational standards

This chapter will help you meet the following National Occupational Standards for Social Work:

Key Role 5: Manage and be accountable, with supervision and support, for your own social work practice within your organization. Unit 15: Contribute to the management of resources and services.

Key Role 6: Demonstrate professional competence in social work practice. Unit 19: Work within agreed standards of social work practice and ensure personal professional development.

It will also help meet the following National Occupational Standards for Mental Health:

Identify trends and changes in the mental health and mental health needs of a population and the effectiveness of different means of meeting their needs (SFHMH 50)

Negotiate and agree with stakeholders the opportunities they are willing to offer to people with mental health needs (SFHMH 72)

Assess the need for, and plan awareness raising of mental health issues (SFHMH 87)

Work with service providers to support people with mental health needs in ways which promote their rights (SFHMH 3)

Learning outcomes

1 To increase your knowledge of mental health policy, mental health providers and organizational change.
2 To develop your skills relating to the management of change – both self and others.
3 To develop your practice working in agencies.

Introduction

All too often social workers will become immersed in practice without fully understanding the crucial policy and agency contexts which will inform and shape judgements made with and about clients and their families. In this early chapter we want you to take a step back from your busy workload and consider how policy making is determined, and then delivered, by the agencies you work in. The chapter begins with a brief overview of key debates about how UK social and health policies are understood and constructed. The sections which follow then focus on particular aspects of mental health policy, beginning with an account of the competing explanations for the rise of the Victorian asylum and the impact these institutions had on patients and professionals and wider society and then noting some of this period's enduring legacy for contemporary policy and practice. The chapter then describes and analyses the key policy themes which are now identified with the period of 'de-' or trans-institutionalization that has occurred in the UK in the last two decades. It then provides a broad overview of key policy themes that re-emerge in the chapters on practice later in the book. These include community-based mental health care, risk management, prevention, empowerment and recovery. We describe and analyse the way in which these policy drivers determine the types of organizations in which mental health social workers are employed and the services that are provided to people with mental health problems. The chapter concludes by arguing that competent, reflective practice is underpinned by a critical awareness of the links between policy drivers, organizational form and social work practice.

Social work and social policy in the UK

For mental health social workers, who have their every working day filled with case load pressures, it can be difficult to understand how and why health and social care policies shape practice. We argue that a core understanding of ideological positions taken about policy-making processes is crucial to the profession.

> Disagreements as to what constitutes good policy or social work practice are rooted in differing values, ideas, and problem definitions. Attempts to penetrate dominant ideas are important in that they force social policy analysts and social work practitioners to ask fundamental questions about possible future developments. (Denny, 1998: 27)

Although it is tempting to view policy making in terms of logical, linear processes, invariably it is the product of competing pressures and contested perspectives in which powerful discourses and constituencies are at play (Lister, 2010). For example, Clarke (2004) explains how the welfare bureaucracies that were constructed during the post-war settlement in the UK were critiqued and redesigned by successive Conservative governments to fit with discourses about new types of welfare delivery with a greater involvement by the market. This new mixed economy of welfare was further refined by subsequent Labour administrations.

Whilst acknowledging that these policy processes are indeed complex, this should not prevent attempts to explore how they function and the way they relate to everyday social work practice. Weiss et al. (2006) have developed a pedagogical model to consider how such questions can be answered when encountered by social work students. They argue that students should have a good knowledge of fields related to social structure and social policy and they should also acquire analytical skills exploring the dimensions of the links between social policy and the goals and values of social work. In addition students should be capable of undertaking a critical examination of social policy and its impact on social work practice. There are many aspects to this interface between social work and social policy; here are a few questions specifically about health and social care policies and the various implications these may have for your clients:

1 *Family policy* – how do such policies differentially affect men and women?
2 *Welfare rights policy* – why is there an increasing use of means tested benefits?
3 *Housing policy* – can you explain the reduced levels of social housing?
4 *Community care policy* – how well does policy and law deal with the burden of care?
5 *Criminal justice policy* – why has there been a shift towards restorative justice practices?

Change and continuity: the origins of mental health policy in the UK

As with generic health and social care policies there is also a need to critically analyse mental health policy. We can understand how mental health policy has developed by examining the many political, social and economic factors that have converged and coalesced at different periods in the history of the UK state. Given the complexity of these events and processes it is not surprising that there are a number of competing histories that seek to explain how and why mental health policies developed in the way that they did (Rogers and Pilgrim, 2009). A particularly influential set of discourses that supported the rise of the Victorian asylum was informed by liberal, Enlightenment ideas that viewed these institutions in terms of a necessary reform of pre-capitalist forms of care and treatment for 'the insane' (Jones, 1960). This positive view of the asylum emerges in historical and contemporary arguments in support of the benefits that psychiatric institutions could deliver both then and now. For example, Borthwick et al. (2001) compare the principles which underlay 'moral treatment' by Tuke in the early nineteenth century with those that underpin contemporary mental health policy two centuries later. Other, less favourable commentaries position the rise of the asylum alongside the political economy of capitalism (Scull, 1977) and with it the need to control and manage

deviant behaviours (Foucault, 1975). At its most coercive, the state had sought to incarcerate and thus used a range of physical, psychological, and latterly medical forms of care and treatment that appear harsh and unforgiving in the light of history. Aspects of this history remain with us today, whether in the physical imagery of surviving Victorian hospitals or in the way the state uses mental health laws to deprive service users of their liberty (a discussion that we will have in the next chapter).

We want to encourage you to think about this notion of the enduring historical legacy of mental health policies and consider how, sometimes surprisingly, this past still has a resonance for contemporary practice. So, consider the following two questions:

Exercise 1.1

1. Is there a Victorian psychiatric hospital in your district? If so, can you trace its history and whether any of your social work colleagues worked there?
2. Have you spoken to older clients, who were patients before the 1980s? If so, what were their experiences of the hospital?

In completing this exercise you may think, as we do, that there are a mixture of possible responses, positive as well as negative. Hundreds of Victorian asylums were built in Britain and Ireland in the nineteenth century. Those that remain continue to be a brooding presence in many towns and cities, instilling fear amongst those citizens who are old enough to remember the hospitals when they were fully functional. For some patients, especially those who were incarcerated for long periods, the institution and its members (including professionals) may have been viewed, on balance, in terms of a collective 'good', offering protection, care and safety from the outside world. Each member of the institution knew and recognized the expected roles and relationships (see our discussion of the work of Goffman in Chapter 3). For others, the asylum was essentially oppressive, where rights and dignity were stripped away, professional power could not be challenged and there was little prospect of returning to the community outside the asylum. Institutionalization describes the largely negative impact of long-term institutional care in which people were rarely asked to make decisions, had little responsibility and spent most of their time relatively under-stimulated and inactive. Other histories also suggest that life outside the asylum could be just as coercive (Bartlett and Wright, 1999).

It is not easy to establish those moments when mental health policy significantly shifted in ways that dramatically affected the lives of service users, carers and professionals (Carpenter, 2009). Often these processes could be slow burning, erratic and hard to determine, but the history of mental health services in the UK can be roughly divided into three main phases: before 1845 when there was little formal system of care; between 1845 and 1961 when the

asylum dominated; and from 1961 until the present with the development of contemporary practices of community care. Before the relatively progressive thinking that was embodied in the 1845 Lunatics Act, which compelled county authorities to establish asylums, people with mental health problems had mainly been subjected to arbitrary, haphazard and often brutal treatment in workhouses, prisons and private madhouses (Pilgrim and Rogers, 1993). Leading up to this legislation there was growing political and public awareness of the lack of mental health services and a number of innovative approaches had attempted to provide more humane care (Jones, 1998). Urbanization, industrialization and professional forces contributed to these changes but in the direction of segregation (Scull, 1977). Following the 1845 Act, the large Victorian asylums totally dominated mental health care until the first official discussions about moving towards community care began following the aftermath of the First World War. A Royal Commission (1924–1926) considered reform and recommended a community service based on treatment in people's homes. Its recommendations were included in the Mental Treatment Act of 1930. Over the next 30 years some progress was made through open door policies, a greater focus on acute care, outpatient clinics, increased public awareness and the development of therapeutic community ideas. However, it was not until the 1950s that the role of institutions as the base for care was first really challenged. Jones (1998) has described this time as involving three revolutions – legal, social and pharmacological. Another factor was the spiralling costs of maintaining the mental hospitals.

The legal revolution began in the early 1950s with a growing concern about the loss of liberty involved in institutional care. This concern led to the creation of another Royal Commission in 1954 whose work was to form the basis of the 1959 Mental Health Act. This legislation confirmed the need to re-orientate mental health services away from institutions towards care in the community. The social revolution was heralded by the publication of a World Health Organisation report in 1953 that offered a new model for the development of community mental health services. In the late 1950s and early 1960s a rush of literature that confirmed the detrimental effects of institutionalization reinforced the need to move towards community-focused services.

The World Health Organisation report was closely followed by the pharmacological revolution that introduced new drugs which alleviated some of the symptoms of mental health problems. Although there was initial optimism about these drugs, their role in deinstitutionalization has perhaps been overplayed. By 1961 Professor Morris Carstairs noted that 'few would claim that our current wonder drugs exercise anything more than a palliative influence on psychiatric disorders. The big change has been rather one of public opinion' (Jones, 1998: 150). The in-patient population in England and Wales had peaked in 1955 at 155,000 and due to the legal, social and pharmacological developments began to decline slowly, with some community services introduced in rather piecemeal ways across the UK. However, in 1961, Enoch Powell, the new Minister for Health, driven by a political desire to reduce public spending (rather than any more therapeutic motive) declared in his

famous Water Tower Speech the intention to attempt to cut the number of psychiatric beds by half in 15 years. This announcement established the pattern that has caused many of our current difficulties – the reduction of hospital beds without the establishment of sufficient community services to support people. Subsequent policy approaches highlighted this concern. Warnings about pursuing dehospitalization without reprovision were identified in 'Better Services for the Mentally Ill' (DHSS, 1975) and by the Social Services Committee of the House of Commons (1985) who stated,

> A decent community-based service for mentally ill or mentally handicapped people cannot be provided at the same overall cost as present services. The proposition that community care should be cost neutral is untenable ... Any fool can close a long-stay hospital: it takes more time and trouble to do it properly and compassionately. (cited in Mind, 2010: 1)

A key theme that has influenced policy in this area throughout the developed world has therefore been the stated intention by governments to move patients from psychiatric hospitals and into the community (even though these concepts in themselves can be hard to define). There are disparate views on which factors can best explain the origins and delivery of these policy agendas, with Scull, in particular, questioning the conventional wisdom that the introduction of new psychotropic drugs in the mid to late 1950s enabled the trend towards rehabilitation in the community to take place. Yet it was not until the 1980s that such a policy began to be only partially recognized. Debates continue about the merits of hospital- and community-based forms of care, confirmed in Thornicroft and Tansella's (2004) review of the evidence. A key factor in assessing mental health systems is the resources available to governments. Where there are limited resources, the literature suggests that investment should take place at the level of primary care. When more resources are available then policy makers are more likely to move away from asylum-based care. This usually happens when governments release funds by engaging in a process of deinstitutionalization. When welfare regimes can afford a stepped care model then important planning and training processes are necessary for successful outcomes. The authors conclude by arguing that a false dichotomy which poses institutional versus community care is not borne out in the evidence and that a pragmatic, integrated approach is necessary in any modern system of mental health care.

Deinstitutionalization and community care

Service users, carers and mental health social workers have to deal with the consequences of this policy, however ill defined it remains. Although there has been a substantial reduction in hospital bed numbers, rates of detention remain high, as illustrated by the graph below taken from McKeown et al.'s (2011) paper on trends in hospital use in England from 1998–2008:

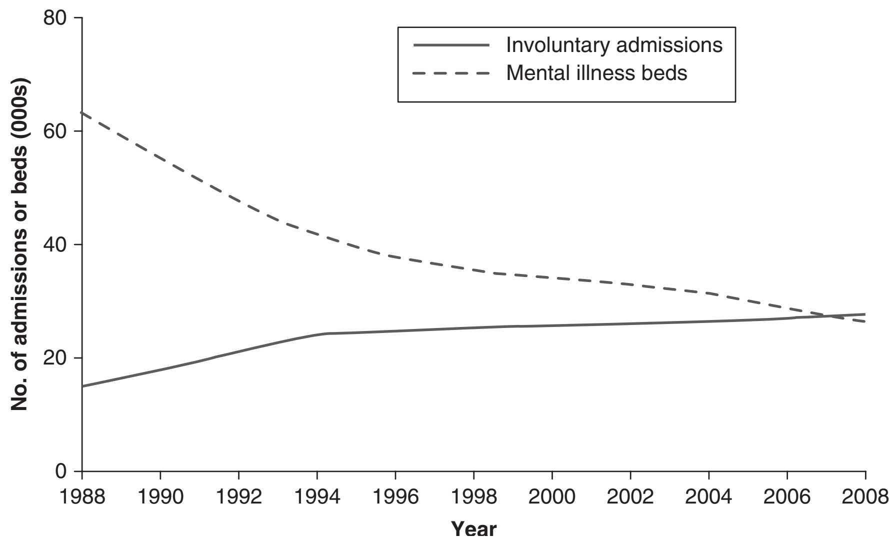

Figure 1.1 Trends in hospital use in England from 1998–2008

Similar trends occurred in Scotland and Northern Ireland, although services are inevitably configured in nuanced ways, depending on the patterns of deinstitutionalization and support for community-based care. As McKeown et al.'s (2011) figure implies, just because bed numbers had been reduced this does not mean that admissions also fell. What emerged during this period was the phenomenon of the 'revolving door syndrome'. This can briefly be explained as follows. As psychiatric bed numbers fell, time spent in hospital was reduced and quicker discharges occurred. In some cases service users were discharged too quickly, or community-based supports were inadequate, so a quicker than usual readmission to hospital occurred (Thompson et al., 2004). Increasing numbers of people were also detained – one assumes because of the lack of support and resource in the community to prevent admission and readmission.

Concerns about this 'revolving door' phenomenon had been recognized by the 1990s and a range of policy initiatives was designed to deal with these transitions. For example, a model of care management that described a process of assessment, planning, intervening and review was to be used with all adult services groups. This model of care planning continues to inform much social work practice in mental health and other services (Payne, 1995). Partly because of concerns about the haphazard nature of community-based care for, and risks to, people with mental health problems, the Care Programme Approach (CPA) was introduced. The idea was that clients judged to be vulnerable should be entitled to an assessment, and, where necessary, a care plan would then be delivered by a named professional, often a social worker. Two decades later, probably as a consequence of limited resources and the problems

of organization, only the most vulnerable and those at immediate risk will receive these services (Golightly, 2008). Another feature of the CPA has been an attempt to record and track decision-making processes within and between the complex network of services that comprise the mental health system. A more recent, but related, policy process directly targeted at the improvement of mental health services is the National Service Framework for Mental Health (NSFMH) (DH, 1999b). Webber (2008) has argued that the standards set by the government in England and Wales (mental health promotion; primary care; access to services for people with severe mental health problems; effective services; caring for carers; preventing suicide) were rational in their intent, but not always underpinned by the evidence provided by government sponsored research projects.

Risk and protection

We mentioned at the start of this chapter that, however enlightened the policy process is in terms of government and civic aspirations towards more efficient, humane and inclusive services for people with mental health problems, concerns about risk and protection remain. These concerns have been intensified as broader principles of care management have been replaced with a more targeted, case management approach in dealing with service users deemed to be most at risk (Kemshall, 2002). In later chapters we will be using case material to illustrate how risk can be assessed and dealt with by mental health social workers, but first we must express a note of caution. In many ways risk can be viewed as a socially constructed concept that has been defined and redefined by policy makers over the years (Cree and Wallace, 2009). For example, many people in the past were admitted to psychiatric hospitals for social and not psychiatric reasons; often these practices adversely affected particular sections of society (Prior, 1999). The more recent policy initiatives (DH, 1999) that focused on one group of people with mental health problems, those described as having dangerously severe personality disorders, fuelled the debates that led to the eventual reform of mental health laws in the UK. This is an especially problematic issue for mental health practitioners because of difficulties with the assessment, diagnosis, care and treatment of people with personality disorders. There is little evidence that compulsory hospitalization leads to good outcomes in these circumstances, and the worry must be that civil legal processes might be used to incarcerate those who are viewed to be dangerous but not obviously subject to the criminal legal process.

Notwithstanding this assumption of some degree of social construction in the way that risk is perceived by policy makers and the wider society, attempts have been made to assess and empirically measure these relationships. Rogers and Pilgrim (2009) summarized the findings from a range of studies and, unsurprisingly, concluded that definitive trends and causal factors were difficult to establish. Findings will tend to vary according to the period studied, with contrasting claims of more or less risk in some populations of people with mental health problems. For example, there are strong claims that people

with substance misuse behaviours and personality disorders are more likely to be dangerous than the normal population. These findings are interesting but not particularly helpful to practitioners and policy makers who would seek concrete answers to how risk can be judged in this field. Gaps in knowledge are also magnified when public inquiries examine homicides caused by people with mental health problems (Stanley and Manthorpe, 2001). What will emerge from these inquiries are appeals for more joined-up communication between health and social care professionals, particularly during the discharge process, and the development of skills and resources in carrying out multi-disciplinary assessments.

It seems ironic, and somehow reflective of public attitudes towards the problems faced by people with mental health problems, that the risk to service users from themselves and others is likely to be much greater than the risk they present to the general public. Mental distress, social isolation and stigma can contribute to feelings of worthlessness and lead to self-harm and suicide. As with the discussion on risk to others, it is nonetheless difficult to disaggregate the causes of these behaviours, not least in the case of suicide when coroners' courts do not always have the evidence of intention available to them to make a decision. Pritchard (2006) uses international figures to highlight the variations in suicide rates across the world and argues for multi-factorial explanations for these rates, including the significance of social and cultural norms and the sudden economic changes that adversely affect societies. For example, there has been an intense debate in Northern Ireland about the effects of the political conflict upon suicide rates (Tomlinson, 2007) and it is reasonable to conclude that, as before, suicides will increase during periods of economic recession. In the UK men are much more likely than women, and younger rather than older people, to be over-represented in statistics on suicide. Those who are depressed, use drugs and alcohol, and experience social isolation are also at risk. Recent figures indicate a general decline in suicides in the UK between 1991 and 2007, with an increase for the last year of combined records, 2008 (www.statistics.gov.uk). Governments across the countries of the UK have recognized the high costs of suicide and developed policies to help prevent suicide (DH, 2002b; Scottish Government, 2002; DHSSPS, 2006; Welsh Assembly, 2008). These policies share common aims in targeting groups at risk, responding to crises and developing preventative services, promoting well-being and recovery, engaging with how the media deals with suicide, and evaluating best practice in the field.

Social inclusion and recovery

There is convincing evidence that people with mental health problems often encounter disadvantages caused by social exclusion (Gomm, 2009). These disadvantages take different forms; for example exclusion from the labour market, which many service users face, is directly associated with the social consequences of being poor. Finding a job is made that much more difficult if you have had or have a mental health problem. In addition the pervasive forms of stigma and

stereotyping to be found in the media and everyday discourses create barriers to social inclusion. During the last decade UK governments have attempted to challenge these forms of discrimination through a series of policy-based initiatives. For example, Standard One of the NSF highlights the requirement for service providers to address mental health promotion and the discrimination and social exclusion faced by mental health service users. The organization and delivery of mental health services should also be shaped by the key policy documents, *Modernising Mental Health Services* (DH, 1998) and the *Mental Health and Social Exclusion* report (SEU, 2004). Despite the fact that this policy agenda has been in existence for over a decade, concerns remain about its success.

Whereas government policies designed to reduce social exclusion seem somewhat remote and disconnected from the lives of people with mental health problems, recent interest in using the concept of recovery has generated a greater sense of hope for change in the mental health system (DH, 2001). Ramon et al. (2007) trace the history of the concept to its central presence in the UK mental health system (NIMHE, 2005). This concept is founded upon a critique of traditional, professional discourses about the care and treatment of people with mental health problems. This pessimism is challenged by ideas on recovery. Increasingly service users are demanding changes to the way services are managed and delivered. Embedded in the concept of recovery is the espousal of a strengths perspective where service users have a say in the services they receive and these services take more optimistic views about past, present and future experiences (Sayce, 2000). We further develop this discussion in Chapters 4 and 5.

Organizational contexts

In the second part of the chapter we now examine the ways in which organizations have developed to account for these policy drivers. We thought we would introduce this section by locating our own professional careers in the policy environments and organizational contexts that existed when we practised. One of us worked as a mental health social worker just at the crossover from hospital to community mental health teams in the late 1980s. This was the beginning of a large-scale process of deinstitutionalization, coinciding with changes to mental health law. The other author practised at a time when community care policy was much more developed and new services were designed to prevent hospitalization. The time was the late 1990s and the organizational unit was a Community Mental Health Team and then an assertive outreach team. In the decade between these two experiences much had happened in terms of the delivery of mental health services; these can be partly explained by factors that were discussed in the first part of this chapter. For example, there was a large reduction in psychiatric bed numbers, and a gradual increase in new forms of community-based care and multi-disciplinary working, growing worries about the management of risk and a greater recognition of the voices of carers and service users. At this point think about your career in the same way by completing the following exercise.

Exercise 1.2

1 Describe how mental health policies have affected the way your organization functioned during your career as a mental health social worker.
2 How have these policies affected the way that you practise?

We would imagine that there are many interesting stories about how your career has progressed in the context of these policy environments when these questions have been answered. Although there are, inevitably, large variations in organizational and practice styles, often determined by the policy contexts in each of the jurisdictions of the UK, it is possible to describe the types of services that have evolved to meet these policy imperatives. We now summarize the key features of these services.

Multi-disciplinary working and community-based care

One of the consequences of large-scale policy initiatives, such as the CPA, has been the pressure on organizations to deliver mental health services using models of multi-disciplinary working (see Chapter 10). This has been a difficult aspiration to achieve, particularly because of the diverse structures of health and social care in the UK. The problematic impact upon the delivery of mental health services caused by the split between health and social care authorities has been well documented (Onyett, 2003) while attempts to bridge organizational and financial arrangements to create a seamless, holistic service have often failed. It is also difficult to bring together professionals (social workers, nurses, psychiatrists, occupational therapists, clinical psychologists) who do not share common educational and practice paradigms. And even when an integrated service exists, it is not clear whether this necessarily delivers good outcomes for service users and carers (Reilly et al., 2007).

As a consequence of the NSFMH in England and Wales, and parallel policy processes elsewhere in the UK, a range of multi-disciplinary teams was established to deliver the promises of community-based care for people with mental health problems and their carers (De Chenu, 2007). Existing Community Mental Health Teams (CMHTs) were subject to various changes to meet new policy requirements. Thus some were situated in primary health care settings as part of a more preventative approach to mental health care and treatment. Other mental health social workers were located in teams that were designed to support service users with more chronic and enduring disorders and, hopefully, prevent their admission and readmission to psychiatric hospital. Assertive Outreach Teams (AOTs) provide intense, round the clock services for service users who have difficulty in functioning and managing everyday living. Crisis Intervention Teams (CITs) provide less planned services, rather their function

is to respond to immediate crises, often dealing with situations of high risk and vulnerability. Early Intervention Teams (EITs) focus on younger people who are at risk of serious mental illness. Freeman and Peck (2006) used a stakeholder approach to evaluate the work of a number of such teams in England, revealing the strengths as well as the problems faced by such services. A significant problem was boundary disputes between generic and specialist teams about how service user needs would 'fit' with the teams' referral criteria. There were also some interprofessional conflicts within teams. On the other hand, these changes offered new opportunities to develop innovative services and therapeutic approaches and holistic assessments were made more possible through these organizational structures. Notably service users and carers were generally positive in their experiences of reconfigured specialist teams. While most mental health social workers will be employed in community teams, a smaller proportion will work in more specialized settings. For example, they may intervene at the interface between the criminal justice and mental health systems as part of a forensic team, deal with the needs of younger people in a Children and Adolescent Mental Health Service (CAMHS) team, or contribute to teams of professionals working with people who have addiction problems. We will use case material in the following chapters to help you explore these interfaces.

Conclusions: implications for mental health social work practice

We began this chapter by arguing that mental health social workers needed to be aware of the policy-making processes that would lead to changes in organizational delivery and professional practice. In particular the last decade has seen quite profound shifts in the way that governments view mental health provision in terms of rolling out community care policies, managing perceived risk and engaging more openly with service users and carers. We will return to these and other themes when we apply theory to social work practice in later chapters of this book. In the meantime, however, it is worth reflecting on the issues that mental health social workers face as a result of these ever-changing policy contexts. We believe that a critical understanding of policy processes can better equip mental health social workers to deliver practice that is mindful of service user and carer need. Bowl (2009) makes a number of important points in this respect. There seems little doubt that, as governments increasingly favour generic, shared mental health professional roles, some social workers will feel that their identity is threatened. Bowl cites the introduction in England and Wales of Support Time and Recovery (STR) Workers and the Approved Mental Health Professional (AMHP) to make this point (see Chapter 11). This concern about the diminution of a distinctive social work role in mental health services is the subject of continuing debate at the levels of both policy and practice, following the reconfiguration of services (NIMHE, 2005). The need for continuous education and training to enable mental health social workers to establish their

credentials can be viewed as a positive response to such challenges. There is also a need to emphasize and re-emphasize the sociological, holistic perspectives that social workers can bring to the processes of assessment and intervention in mental health services (Gould, 2006). It may also be reasonable to assume that mental health social workers are better equipped to understand the impact of policy processes than other professional colleagues. Rapaport (2005), in her account of the development of the mental health social work role in England and Wales, traces a series of setbacks and some successes in the way that the role was constructed and re-worked in the post-war period. Her argument is that some of the erosion of the social work role occurred with the advent of multi-disciplinary teams and AMHPs in England and Wales. Although there are similar concerns elsewhere in the UK, the preservation of the sole legal function for social workers in Scotland and Northern Ireland at least partly assuages these concerns. The message, however, remains the same: social workers have to be more politically aware and prepared to advocate for their position at the level of policy making. We hope that now you have read this chapter this relationship between the professional activity of mental health social workers and wider policy agendas is clearer and its importance has been highlighted.

Recommended reading

For a comprehensive description and analysis of the historical development of mental health policy and services see the following Mind website:

www.mind.org.uk/help/research_and_policy/notes_on_the_history_of_mental_health_care

Pilgrim and Ramon provide a thorough, critical review of how mental health policy in the UK developed over the period of recent Labour governments:

Pilgrim and Ramon (2009) 'English mental health policy under New Labour', *Policy and Politics*, 37 (2): 273–88.