ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 – 1346

POWER AND POLITICS IN UK MENTAL HEALTH SERVICES

Grace Hurford
Department of Politics
Nottingham Trent University

Thesis submitted in partial fulfilment of the requirement of
The Nottingham Trent University
for the degree of Doctor of Philosophy

September 2001

ACKNOWLEDGEMENTS

My grateful thanks are due to my Supervisors: Professor Christine Bellamy and Doctor Colin Fisher, and to Sandra Odell for administrative and moral support. I would also like to thank all the respondents who took part in the fieldwork, in the NHS, Social Services and the voluntary sector. I would also particularly like to thank David King, former District Administrator, from Exeter Health Authority, where it all started in 1983. Finally, my thanks to my family, for their patience and support.

Grace Hurford
September 2001

ABSTRACT

This thesis explores the way that policy has worked in UK mental health services, over the last twenty years. It constructs a framework for analysing three stages of policy making: namely policy initiation, policy formulation and policy implementation. Three levels of policy activity are also identified; these are located at the Macro, national level, the Meso, district health authority (DHA) level and the Micro, provider level. A matrix is then built up that facilitates an exploration of policy activity within and between these stages and levels. The study looked at the policy activity of managers and civil servants in the Department of Health, four DHAs and four provider units, as well as two mental health pressure groups. Research methods included participant observation, interviews, documentary analysis and questionnaires. The main findings of the study are that, historically, no level has held a monopoly on power or influence in the policy process, that the hitherto un-sung role of the Meso level has been crucial for policy success, and that managers' abilities to shape their organisations decline above the Meso level. Since a new Labour Government came to power in 1997, however, the Macro level has begun to dominate the policy process. The ensuing 'top down' approach to policy formulation is ensuring uniformity of service, but may be stifling creativity. Policy activity is becoming less than the sum of its parts.

TABLE OF CONTENTS

CHAPTER ONE:
INTRODUCTION

The purpose of this research is to explore how policy making works in mental health services in the UK. Over the last century, the key mental health policy that has unfolded is that of 'care in the community' and it is this policy, what foreshadowed it and what followed it, that is the focus of this study. This thesis includes a historical review of mental health services over this period and the institutions and processes through which mental health policy flows. It also includes a summary of the different approaches available in studying policymaking, and considers the most appropriate approach in this field. It attempts to do what many eminent researchers have assiduously avoided when analysing public policy by dealing with both policy making **and** implementation. It also takes into account the personalities and people who have shaped the policies and concerns itself with the external as well as the internal processes of the organisations concerned.

Mental health policy, like much public policy, does not have a clear beginning, middle or end – and so to focus exclusively on policy formulation or implementation would severely limit the research. It would preclude any analysis of the relationship between and beyond these stages. It would also cause difficulties when attempting to look at outcomes and how they are affected by early policy. In short, the research attempts to tell the whole story, though not always in chronological order. Taking into account the personalities and people who have shaped mental health policies throughout the recent history of mental health services should enrich our understanding of individual actions, as well as providing an interesting and identifiable foreground of characters to the story. Rather than examining policy through concepts solely drawn from academic theories and interpretation, the intention was to draw on the experiences and perceptions of the politicians, managers and professionals involved in the decision making process. This will not give a complete picture – but what people tell us helps us to understand their

beliefs, culture and values as well as forming a comparison between what different people think happened and official documentary narration. There is also a backdrop to this story which is composed of more global forces, relationships and structures of mental health policy in the UK.

When deciding where to draw the boundaries of the research, the scope has been somewhat widened by the inclusion of groups and interests essentially 'external' to the organisations concerned. The internal scope of the organisation includes the NHS, its staff (bureaucrats and professionals) as well as politicians and various sectors of social services, and the bulk of the research focus is on this internal group. The external scope does not include patients, relatives or carers but does include pressure groups representing these individuals. There is also a less clear 'quango' sector which includes inspectors, task forces and think tanks who are more or less independent of government and the internal organisation, and who have more or less influence on government policy, specifically mental health policy. These external groups are the background characters to the research setting, and it is important to state from the outset that these groups were included in the research in the context of their relationships to internal actors, and in connection with the way they affected mental health policy. In terms of the actual story, a little more needs to be said. When setting out to explore how policy unfolds in UK mental health services, the intention was to track policy as it was initiated, formulated and subsequently implemented: examining how the different stages interacted, and what influenced, changed and re- shaped policy through this process. A number of initial findings emerged which were accurate in a historical sense, but which were challenged in the latter part of the research period, as circumstances and governments changed. The first finding was that policy initiation and formulation was, historically, anything but a top down process. The second finding was the significant extent to which senior civil servants and professionals manipulated and controlled their politicians. This was not just at the national level of policy making, as the study discovered that performance measures and statistics demanded by the centre were at times made up or estimated by the intermediate level, and the

centre either had no method for verifying these statistics, or did not wish to. Quoting a public health specialist in the context of performance measure demands sums up the attitude of the intermediate level to the centre: 'Feeding the beast'. The third finding to emerge was the difficulties experienced by the centre in controlling policy delivery. These three findings were consistent across fifteen years from 1983 to 1998. These findings echo other research in health policy in the UK regarding the relationship between the centre and the periphery (Harrison, Hunter & Pollitt, 1990). Wider studies on the relationship between the British Government and the various policy communities suggest that the centre cannot 'prevent resistance to its policies, or ... ensure that it always obtains the results it wants' (Elcock, 1991: 203). But in the health policy field, there is very little said about the intermediate level and how it relates upwards and downwards. What emerged as a result of these initial findings was the intriguing role of the intermediary bodies between the policy makers and the policy implementers. What did they do, and how did they influence policy?

These initial findings raised further questions of course, and in order to look systematically and in more detail at how policy unfolded, I selected key themes that seemed to lie at the heart of policy making in the UK. A number of writers had researched into the impact of single themes, but it was clear that examining these themes individually and as interacting components would yield much richer results. These themes included:

- Power relationships and the structures which facilitate and constrain them;
- Knowledge and advice in the decision making process;
- Language and culture in the organisation;
- Rationality and other approaches to formulating policy;
- The impact of people on the organisation, and the organisation on people;
- The use of discretion in the policy process;

- Linking stages of policy;
- Difficulties in implementing policy.

The themes are not exhaustive, or even mutually exclusive. But they show different aspects to mental health policy, which complement each other, and assist in telling the 'whole story.' These themes crop up in various stages of the policy making process, sometimes more than once, and are tackled when they occur, as policy unfolds. They provide the basis for an exploration of *how* mental health policy making in the UK has unfolded over the last thirty years and the *reasons* behind the implementation (or lack of implementation) of different policy measures over this period of time.

There was a multiplicity of perspectives from which to choose from, when examining how policy making worked in the UK, and these perspectives needed to be considered in relation to mental health policy making in particular. The literature search and knowledge from working in the mental health field suggested that there were specific challenges and constraints as well as freedoms for policy actors in mental health that made this a fruitful area to research. The scope of Chapter Two includes a review of the unique factors in the mental health policy field. In brief, the most significant are that most health experts would agree that there is no agreement as to what constitutes mental health or illness, that any facts and figures in the mental health field therefore need to be treated with caution and that the disputed nature of issues and problems in mental health renders the relationships between professionals and managers as well as politicians quite different from other branches of health care. The accompanying territory that is occupied by the professionals, managers, politicians and pressure groups is, therefore, going to be much less clearly demarcated. The impact of politicians on policy making is frequently studied, but there is very little research carried out on the impact of managers and officials on mental health policy, despite all the discretion and choice they might have in policy matters, judging by the above aspects. This study, therefore, addresses particularly the role of managers and officials in mental health policy making, as well as that of professionals and consumer pressure

groups. Mental health policy changes have been similarly distinctive, resulting from a complex interaction of changing state policies, social movements, economic imperatives and clinical practices and values that have been more diverse than factors affecting other branches of health care.

A further unique aspect to the examination of mental health policy in the last century is that it is essentially a study of a perceived policy 'failure' despite all the evidence from users, professionals and managers at the 'sharp end' that the possible alternatives were much worse. This difference in perception highlights the difficulty of defining what we mean in public services by policy failure and success. As we shall see there is a significant difference between the idea or concept of community care, and fully fledged policies that make it a reality, but it is more common for commentators to point out deficiencies of policy than to praise the successes. When considering success or failure of mental health policies, a key theme that emerges is the inter-related nature of public policy, particularly when governments are responding to crises. Altering one area of public policy may have unforeseen consequences on other policy areas. So if we are examining how governments shape mental health policy, paying attention to the 'policy crises' will include scrutiny of wider policy areas than might first be supposed. I refer to this spin-off effect as: *old sins casting long shadows.*

Given these unique and special factors that shape mental health services and policies, it seemed important to develop a conceptual framework for the study which could be used to structure the direction and scope of the research and bring into account these distinctive factors. The framework that was developed was based on a broadly linear approach to policy making, with the attention focused on three main *stages* of policy making: policy initiation, policy formulation and policy implementation. Although a linear approach has its drawbacks, it does enable the researcher to 'follow through' a policy from beginning to end and to preserve the chronology that is so important in documenting events that have occurred over the last thirty years. The organisational context was then mapped out to locate where policy activity might occur, and three main *levels* were identified: the Macro (national) level, the Meso

(bridging or intermediate) level and the Micro (delivery) level. These levels of policy-making and stages of policy process were then expressed as a matrix which directed the remainder of the study. An important and inter-related component to the conceptual framework was a series of Venn diagrams, mapping the varying dynamics between the policy stages (initiation, formulation and implementation) and three different possibilities were modelled: the fractal, the reductive and the dynamic models. The Venn diagrams are complementary to the matrix model, in that they helped to explore the relationships *between* the stages of policy making, and allowed for the possibility of an iterative approach in the policy process. The matrix enabled exploration and charting of the policy activity that was taking place and where it was occurring over time. The Venn diagrams mapped relationships between the stages of policy making and demonstrated the fit between implemented policies and the original policies initiated and formulated in different cases over the last thirty years. Developing the conceptual framework was a critical part of the research, as it then formed the structure for the rest of the thesis. It pointed the way to very clear research methods and choices, in that it both directed attention to specific locations and actors, and framed the research questions that needed to be answered in order to gain a greater understanding of the mental health policy process in the UK.

The main findings of the research can initially be summarised under the Macro, Meso and Micro level approaches to policy making, and as might be expected, different levels behaved differently at different times. The Macro level, historically, appeared to be much more concerned with wider interests and power than the Meso and Micro levels, although there was at least one key 'decision point' that is identified in 1969, when there was an *imperative to act* emanating from a politician's decision to over-ride the advice of his civil servants and to take action on what seemed to be the basis of values and beliefs. The Meso level has had a significant, but unsung, part to play in shaping mental health policy over the years, and with the introduction of the internal market in 1991 this level gradually strengthened its role still further. The Meso level district health authorities investigated have historically attempted to be logical and systematic in formulating policy, and there is

evidence of the important role of ideas and a policy network at this level. This level has, however, had to take into account interest groups and political pressures, although not to the same extent as the Macro level. Over the last five years, there is significant evidence of user involvement in planning and shaping mental health policy at the Meso level, with resources, training and structures put in place to assist in this process in the DHAs analysed. The Micro level has perhaps undergone the most violent shifts in policy approaches, with the 'early mover' units of the early 1980s having 'total and absolute' discretion in how they implemented policy, and the 'later movers' of the late 1980s and the early 1990s having to negotiate terms somewhat with the DHAs. The provider units in the late 1990s then lost significant control and discretion over their own affairs, firstly to the DHAs as the Meso level grew in expertise and knowledge in the contracting process, and secondly to the Macro level with a change in government and a completely different approach to measurement and control. The Micro level has perhaps struggled more than the other levels in achieving a balance between involving users in policy making, and finding a practical way of integrating all the disparate views of such a wide ranging constituency. This is perhaps because of their responsibility for 'putting the rhetoric into action.' The evidence from the Micro level units that were reviewed suggests that there is still a gap between the rhetoric of user involvement and real empowerment and integration of user needs and views.

The findings can also be viewed through the conceptual framework identified earlier in this Chapter, that is through the matrix and the Venn diagrams. Certainly the different Micro units and Meso DHAs have exhibited quite different dynamics between the policy stages over the last thirty years. The 'early movers' tended to inhabit the *fractal* Venn diagram, whilst the 'later movers' and the 'contract culture' of the 1990s tended to inhabit the *dynamic* Venn diagram. The 'New Labour' DHAs and Micro units at the end of the 1990s fitted the '*reductive*' Venn diagram. When the relationship between the hierarchical levels and the stages of policy making are explored through the matrix outlined earlier, it is possible to identify specific times in history when

the matrix can be completed in quite different ways. For example, in 1969, there was no implementation occurring, policy was being initiated at all levels, and policy was specifically formulated at the Macro level. However, if we examine events in 1983, there is compelling evidence of policy being initiated and formulated *jointly* between one DHA and a provider unit, with the provider unit implementing policy for the first time: the early mover. At the Macro level at this time, there was no evidence of policy activity, rather the reverse. By the end of the century, the majority of policy formulation, and to a lesser extent policy initiation, was being carried out at the Macro level. The Micro level was expected to implement government policy without deviation, and the Meso level was to be abolished. The significance of these varying compositions of policy action is that no particular level has held a monopoly on policy initiation or formulation throughout the last thirty years. The rise in power and influence of the Meso level in the early 1990s did not suggest that this level was threatened. Yet the abolition of the DHAs will come into effect in 2002, and most power appears to be draining towards the Macro level. This recent shift in the balance of policy activity between the different levels has occurred for a variety of reasons. Whilst there are obvious forces shaping policy activity such as power and interests, it is important not to underestimate the role of ideas and culture in shaping policy as well. This is particularly important when considering the way in which organisations shape individual actions, and the way in which individuals are able to shape the wider organisation. There appears to be an invisible ceiling beyond which individuals struggle to shape their organisation, and this tends to be located at the Meso level. At the Micro and Meso levels, there is evidence that individual managers and professionals can have a significant cultural effect on their teams and their units, but at the Macro level, the *discourse* of officials excludes any reference to this type of cultural autonomy. If Macro level individuals are shaping their organisation, they are doing so unknowingly. This 'unknowing' also manifests itself in professionals at the Micro level. They do not consider that they have any discretion at all in implementing policy, but when they are questioned about their referral choices, their diagnostic decisions and the way they classify problems, it is reasonable to

conclude that they do exert some influence in the policy process. The only monopoly on policy activity is held by the Micro level in policy implementation. The other levels very rarely get involved, except in a crisis. However, the mixed economy of care in health generally, and mental health services in particular, is flourishing. There is no sign of this strategy abating with the current Labour Government, and mental health services are now delivered by the private sector, the not for profit voluntary sector and of course through carers and relatives in the home, as well as health and social services units. So it would be inaccurate to assert that any single organisation has the monopoly in implementing and delivering policy either. How can a government possibly control and hold to account such a diverse range of agencies in the delivery of mental health care? The way that this current government has responded is to adopt a very formal top-down approach to policy making, paying great attention to detail, instructing the delivery units in exactly the way in which policies should be implemented. This has some advantages, providing that policy implementers agree with the values and direction shaped at the Macro level. But there are risks to this response, and these include the use of negative and covert power at the Micro level, as well as a lack of innovation that is likely to occur at this level with such a prescriptive approach. These issues and others are discussed in more detail in the final chapter.

The following chapters attempt to outline the journey taken to discover how mental health policy making works in the UK. This journey starts in Chapter Two by describing the background to mental health services in the UK, its history and its politics. Whilst many writers have concerned themselves with public policy, and some writers have considered health policy, very few have focused specifically on mental health policy. This is a little surprising considering the structural and cultural changes in this field over the last thirty years, particularly with the shift from institutional to community care. So Chapter Two sets the scene for the research, as well as providing a rationale for the lack of policy analysis in this field to date. The conceptual framework is then developed in Chapter Three and from this the research strategy in

Chapter Four. The subsequent three chapters (Five, Six and Seven) consider how mental health policy has been initiated, formulated and implemented in the UK over the last thirty years, and Chapter Eight puts the findings together, and considers the wider implications for policy making in the UK.

CHAPTER TWO:
BACKGROUND TO MENTAL HEALTH SERVICES IN THE UK.

There are two types of time: there is the time that waits and the time that hopes.

Jacques Brel (transl) in Ramon, 1996.

Introduction

In this chapter, the recent history of the community care policy is briefly reviewed, as well as its antecedents over the last century. The whole construct of mental illness and health is also considered, as there are some unique issues associated with defining mental health that go some way towards explaining the policy difficulties within which successive governments have found themselves. The nature of mental health service change is discussed, and reasons for the protracted time-scale for the evolution of community care are considered. The location of mental health within the study of social policy is reviewed, particularly as it relates to the importance or otherwise that successive governments have placed upon this area of policy. Various points in mental health policy history this last century that have been construed as *crises* are highlighted, and the possible links to other factors are noted, particularly that of government legitimacy and the role of ideas. The importance of wider social policy and its effects on mental health policy is discussed. Drawing together the factors of legitimacy, crisis and the inter-related nature of social policy demonstrates the difficulty of identifying the original *trigger* issue that creates a crisis, and hence the challenges inherent in separating causal and contributory factors in a crisis. The chapter concludes by summarising the more recent history of mental health services in the UK, that is when the long period of community care as an ideology ended and the short period of community care as a reality began. Whilst I would not wish to imply that the community care policy is a perfect policy, the evidence from many people with poor mental health (C. McCourt Perring, 1992; Knapp, Beecham & Cambridge, 1992;) suggests that it is a considerable improvement on what occurred before. This

division is what I have defined (from Jacques Brel in Ramon, 1996) as the *end of the time that waits and the beginning of a time that hopes.*

2.1 Mental health and illness: 'facts' and figures

Most health experts would agree that there is no agreement as to what constitutes mental health or illness. The 'mainstream' of psychiatry defines mental health as the absence of illness, and mental illness as a disruption in 'ordinary functioning.' The reasons for such disruption are argued to stem from underlying biological factors but can be triggered at times by psychological and social factors (Wing, 1978). Because the definition of 'ordinary functioning' will vary from culture to culture and the unusual behaviour, feelings and thoughts associated with mental illness are disputed by professionals, carers and sufferers alike, it is fair to conclude that mental health and illness are partly *social constructs* that depend on the particular interpretation of the influential actors in a specific situation (Ramon, 1996: 9). The policy implications of this are that any facts and figures in the mental health field need to be treated with caution, as different statistics can be collected based on different definitions of illness and health. Comparisons between different cultures and countries will also be difficult. For example, if we simply compare the different national rates of mental illness (per 1000 people) in different countries these can vary from 43.9 in Denmark to 85.4 in Ireland and 1.7 in the UK. (Council of Europe,1993: 22-34.) If we examine the data a little more carefully however, we note that these figures represent people in hospital. But it clearly would be unwise to draw any real conclusions from this data, except that there are probably more mentally ill people living in the community in the UK, than in Ireland or Denmark. If we note the British Mental Health Foundation's estimate that about six million people (or ten percent of the population) in the UK suffer from mental distress of whom about 60 000 are hospital inpatients, then we can deduce that, of the people in the UK who suffer in poor mental health, only one percent of them are receiving hospital treatment, and the other 99 percent are

coping in the community. But what sort of lives they lead, how they are supported and whether this balance between hospital and community is satisfactory or not is going to be assessed in different ways by different groups.

One of the few areas of mental illness that could be amenable to measurement is that of suicide rates. However, even here, confusion can arise. Different cultures might be more or less likely to register deaths due to self-harm as suicide, depending on the prevailing values, religious views and traditions of that country or region. Suicide may be attempted as a result of a mental illness, but it may also emerge without any such state being identified (Ramon, 1996: 11). However, we could argue that anyone attempting suicide is suffering from emotional or psychological (or possibly physical) distress, and hence we will approach suicide as a mental health 'problem', from a social construction. The concept of issues translating into problems, and the way this transformation occurs is a recurring theme in policy analysis and is particularly relevant in the field of mental health, precisely because of the *disputed nature* of issues and problems in mental health and the accompanying *territory* that is occupied by the professionals, politicians and pressure groups to varying degrees. There are at least two divergent perspectives which professionals may hold when treating people who attempt suicide, which highlight the basic territorial conflicts between traditional psychiatrists and the newer professions such as sociologists, social workers and psychologists. People who self-harm can either be treated as though they are mentally ill, because otherwise they would not break the social ethics and norms within our society, or they can be treated as individuals who are experiencing a sense of despair or lack of purpose and control, whereby a suicide attempt is a cry for help and a successful attempt is an act of escape and revenge. (Ramon, 1996: 14.) These divergent views are of course bridged by many professionals, and one can see the merits of both views depending on individual cases. It is this *distinctiveness* of individual cases, the *deficiency of knowledge* we globally hold about how the mind works, particularly in comparison to the physiology of the body, and the *lack of clear definitions* in this

field that present such challenges to policy makers who are responsible for planning mental health services. The history of UK mental health services and policies should therefore be considered in the light of these factors.

2.2 A recent history of UK mental health policies and services.

Some changes arise 'suddenly by force of circumstance or through the burgeoning of a new idea or the surprise breakdown of old practices' (Pettigrew et al, 1992: 145). In health services this could be characterised by crises such as managing HIV and AIDS. In mental health services, however, we have not witnessed such condensed time-scales or specific impacts. Instead, change seemed to evolve as a 'protracted historical movement away from custodial care towards a diffuse range of community based services' (Pettigrew et al, 1992) and resulted from a complex interaction of changing state policies, social movements, economic imperatives and medical practices and values (Busfield 1986, McKee 1988). This evolutionary process and the changes in policy that are associated with it are the subject of this study. Essentially any such study in this century is a study of an historical change from institutional care to community based care. The history of the community care policy is perceived to be an unsatisfactory one and has been described at worst as a policy failure - 'a patchwork of broken promises and moral posturing' (Malin, 1994: 3), and, at best, subject to delays and variability - 'Despite exceptions, the overall picture was bleak. Instead of DHAs and local authorities advancing towards some unitary ideal, there were marked inter Britain differences in interpreting and implementing national policy' (Pettigrew et al, 1992: 149). 'Despite a long established policy in favour of community care and the reduction of institutional care, the history of its implementation has been notable for its slow pace and unevenness' (Hunter, 1992: 170). We are therefore considering a policy that has by all accounts been a 'failure' to some extent or other. But policy failures are relative, and it only takes a quick look around Europe to see that with the exception of Italy (a special case) mental health care in the community and the

empowerment of its users in the UK is *relatively* advanced. Italy is the only country in Europe that used the legislative process to close hospitals and force the pace of community care, through the Mental Treatment Act of 1978. (Law 180). This Act prohibited the building of new psychiatric hospitals, halted admissions to the old hospitals, and provided a maximum of 15 bed wards in general hospitals per 200 000 inhabitants. This revolutionary approach to mental health services was orchestrated by an extraordinary group of powerful professionals who harnessed public support, and forced the less than radical Italian government to act decisively. By 1985, the majority of Italian psychiatric hospitals were closed and mental health community centres provided the bulk of services. However, this is an unusual and very different case from the UK, which has not used the legislative process to close hospitals or to stipulate the composition of new services.

The longer term history of mental health service development in the UK yields clues as to the ponderous and faltering nature of recent policy changes; the antecedents to this policy have roots in the 1930s and earlier. Busfield (1986) identifies *three* historical phases in mental health services: The 'period of *commercial and charitable healing'* of the seventeenth and eighteenth centuries; the period of *public asylums* with 'heavy state sponsorship and legislative powers' typical of the nineteenth century; and the present day 'thrust towards *community* care and non-institutional therapies.' It has already been noted that current policies have been implemented in a protracted and uneven way. Significantly the first and second periods of mental health service development evolved similarly slowly and unevenly: 'Both ... phases of care ... demonstrate halting progress spanning over one hundred years of non-linear change with advances and retreats occurring simultaneously.' (Pettigrew et al 1992: 147). Given the history of delay and variation in service development over the last two hundred years, perhaps we should not be surprised at the relative strength of the *status quo*. However comparisons with the development of other forms of health care in the 1960 and 1970s, where there was an explosion of new

technology treatments and accompanying services, do suggest that mental health service development was comparatively slow. In fact it is possible to argue that the service was in *retreat* after significant new developments between the wars and until the 1960s. Busfield (1986) regards the Mental Health Act of 1930 as the foundation for the community care policy - the Act focused on voluntary admission, strengthened the concept of 'patients' and introduced the term 'hospital.' Former custodial practices were replaced by therapeutic and rehabilitative ones. A key principle underpinning this movement and of 'growing significance on evolving policy' (Hunter 1992: 171) was the 'normalisation' philosophy shaped by Wolfensberger in the 1960s, which 'seeks to ensure for dependent individuals the right to live a life as near to normal as possible.' This approach was initially influential in the development of thinking about care for people with learning disabilities, but quickly became integrated into the development of services for the mentally ill. At its core, 'normalisation' principles emphasised the right of each individual to be valued and to participate in things that sustained, expressed or accorded his or her value. This philosophy has commonly been viewed as affecting mental health policy in two ways: it has provided a values base for formulating policy, and at implementation level has also 'led to the increasing appreciation of the role and importance of ordinary housing .. being located at the core of community care programmes' (Hunter, 1992: 172). New psychotropic drugs, the growth of patients' rights in the 1959 Mental Health Act, developments in social psychiatry, the 'anti-psychiatry' lobby and the post-war establishments of general hospital psychiatric units were all influential in the gradual movement to replace the large mental illness institutions.

The philosophy of normalisation seems to have come about at the end of a decade where community care policy gained 'real status' (Pettigrew et al, 1992: 148) as more able patients were either not admitted or moved out of hospital during this period. The 1960s optimistic view was encapsulated in the Hospital Plan White Paper (Cmnd 1604, 1962) predicting a halving of psychiatric beds

and the widespread closure of beds over the next fifteen years. This should have been a spring-board for great change. However, there was then a period of stagnation throughout this decade, which was finally unblocked by the frustrated Secretary of State for Health (Crossman) in 1969. The Ely Hospital Report (Cmnd 3975, 1969) on scandalous conditions in institutions was published in full, Regional Health Boards were directed to divert money into this sector and the Health Advisory Service was set up to inspect institutions and report back directly to the Secretary of State. There followed another lull for at least ten years, and the predicted widespread closure of beds did not occur. That these proposals were optimistic if not unrealistic was becoming recognised by the early 1980s; changes in service pattern and alternative provision were observed as uniformly protracted and uneven (McKee 1988, Tomlinson 1988, Korman & Glennester 1990). Twice, between 1950 and 1980, government mental health policy had ground to a halt. What had gone wrong, and why, thirty years later, did the care in the community policy rise again from the ashes? To begin to answer this question, we need to consider how policies fit into wider social structures, and how politicians as well as civil servants view this relationship.

2.3 Emerging policy perspectives

Mental health policies are part of a larger social policy structure within the UK relating to marginalised groups in society. However most texts on social policy do not even mention the area of mental health (Ramon, 1996) and this may give clues as to the importance which politicians and the public give it. Policies are made in the 'real world' that has to take account of economic, cultural and political considerations, and if we examine these at a national level a number of themes emerge.

If we examine economic considerations, the UK government, like many of its European counterparts, is heavily influenced by cost-cutting, though more in the newer community services than in relation to established hospital beds. (Hunter,

1992). This erosion of the newer community services may be associated with pressure from vested interest groups, including the medical profession (whose status and performance has traditionally been measured by beds occupied) and relatives and carers who, more than most, might have mixed views about care in the community. A related utilitarian motive attributed to government thinking is that of efficiency (Ramon, 1996) and, certainly, half-empty psychiatric hospitals do not appear to be a rational use of resources. However, if the rationale for closing hospitals was merely utilitarian, it would not explain what happened to all the human resources that appear to have been lost along the way, or the lack of infrastructure developed in the community that resulted in patients returning to hospital after discharge – the *revolving door* syndrome. Whilst economic and efficiency considerations may have shaped government thinking, they do not tell us the whole story. Cultural considerations are similarly important. Different countries have developed different solutions to caring for the mentally ill, and the UK's approach, from the early eighteenth century, was towards the confinement and isolation of these people. However, not all countries adopted this solution, and countries such as Spain, and Italy to a lesser extent, tended to continue to keep mentally ill people in their local communities. So when we examine how the care in the community policy has evolved in the UK, we need to take into account the very long shadows that institutional isolation has cast, culturally, over the last two centuries. When examining political considerations it is clear that no government would seriously consider policy options that do not serve them politically. So any debate on such options will be fuelled by a range of prejudices and motives, giving rise to policies that are full of ambiguities and contradictions: 'Therefore governments are influenced by more groups and factors than they would perhaps like to admit' (Ramon, 1996: 17). This certainly seems to be the case with mental health policies on the surface, though it will be necessary to explore these influences in more detail before assessing the rationality or otherwise of the UK mental health policy process. All these considerations can then be mediated by quite different factors before policy 'takes off' and if we examine the examples of community care unfolding across

Europe, Ramon observes that such factors can have very different impacts in different countries:

> It would therefore seem that the crucial factors in determining whether a member state is able to go ahead with a de-hospitalisation programme depends on the combined effect of the motivation of its mental health professionals, its politicians, and the system of health and social care delivery. (Ramon, 1996: 29).

We could usefully add to this summary of actors and structures the important role of the managers and officials who get involved in shaping policy, both nationally and locally in the UK. In fact, this study includes the hitherto unexplored but key roles of managers and officials in the UK mental health policy process.

2.4 A Policy Crisis?

The nature of the mental health policy process is therefore complicated by the number of groups and factors which impinge on the process, and it is easy to see how predominantly reactive governments are more likely to have policy changes demanded of them, than to initiate change. However there are times when governments have to be seen to be doing more than this: a *policy crisis.* If the government's competence to make decisions is called into question, normally in response to a series of crises or scandals, they will then be forced to make what *appear* to be radical policy decisions in order to regain their authority. The word 'appear' is used advisedly. A recent example of the UK government making a quasi-radical policy decision was in response to a limited number of incidents involving mentally ill people attacking members of the public. The introduction of an 'At Risk' Register listing discharged patients who might be at risk to themselves or others was imposed on all UK hospitals in 1994. Most units struggled to implement such a policy, and there were no accompanying resources to make any difference to the outcomes of such a policy, nor was the policy ever evaluated or measured by the government. However, something was

'seen to be done' and there was a tangible piece of evidence to show for it: the 'Register'.

The overall care in the community policy could not be construed as a truly radical policy in the widest sense, as other countries were successfully implementing community care plans, albeit with less infrastructure to dismantle in some cases. In the UK the policy was quite different from what existed already, although the concept of such a policy has been embedded in the political and social structures in this country since at least the 1930s. But as we shall see, there is a significant difference between the idea or concept of community care, and fully-fledged policies that make it a reality. An important final factor that we need to take into account when considering the legitimacy or otherwise of governments to make policy is how a single change in social policy can affect other policies. People with poor mental health are usually poor people (Ramon, 1996: 23) so any changes in welfare benefits or social security systems, for example, will have a knock on effect on mental health policy success or failure as well. This could be dubbed a *domino effect* in that tinkering with one aspect of policy could have a wider detrimental effect on individuals' mental health, which could then precipitate a policy crisis. Significantly, the 'crisis' that is precipitated may not be obviously or directly related to the original policy change. So if we are examining how governments shape mental health policy, paying attention to the 'legitimation crises' will include scrutiny of wider policy areas than might first be supposed: *old sins cast long shadows.*

2.5 Endings and beginnings

If it is necessary to select a single point in mental health history that divides the past from the present, the move away from reliance on psychiatric hospitals as the *centre* of mental health services in the UK, and Western Europe too, would serve better than most. This policy shift, which took place in the very early 1980s was driven by a number of factors, many of which were not peculiar to the

UK:

- Cross fertilisation: the examples of the USA in the 1960s and Italy in the 1970s provided evidence that people with long term mental illness could live in the community;
- High maintenance costs of the old hospitals, coupled with a move to 'free market' economic policies and resultant ideological focus on public expenditure reduction;
- A gradual decrease in the number of first admissions to hospital and a significant reduction in stay (due to psychotropic drugs, and other alternative interventions);
- The gradual development of alternative community services.

All the above factors were not enough however. A critique of the *hospital as a social institution* was considered to be 'central to the formulation of the new policy' (Ramon, 1996) and came in four sources (Hall & Brockington, 1990): from psychiatrists and psychologists in the USA, from psychiatrists, psychologists and social workers in the UK, from Italian psychiatrists, social workers, nurses and sociologists, and from service users initially in the USA, and later from Europe. The only group cited by Ramon not to criticise hospitals were relatives, who were 'obviously keen on retaining a space that lets them off the hook both ideologically and practically.' (1996: 28). However, this critique of the *hospital as a social institution*, laudable though it was, may not necessarily be the *primary* reason for this distinct policy shift. It certainly does not explain why some hospitals closed so much earlier than others in the UK. In fact none of the other factors cited go anywhere near to explaining these discrepancies and divergences. If we take a closer look at these differences we note that writers have cited numerous reasons for the delay and variation in development. They tend to fall into three distinct yet inter-linked groups: structural, economic and organisational (Audit Commission 1986, Nodder Report 1980). The Nodder Report (1980) did not see delays as being solely the

result of resource constraints, but considered that fundamental change required more central direction to regions and areas through objective setting and targets, the restructuring and strengthening of local management, and co-ordination of health and social services planning (structural and organisational issues). Ironically, the 'Patients First' reorganisation coming into place in 1982 abolished the health tier which was co terminous with local authorities - the area health authorities - further adding to the structural problems facing mental health planners.

Klein's analysis focuses on two weaknesses in policy making in mental health services: 'The limited ability of the centre to shape the pattern of services at the periphery' - which could be defined as a **structural** problem – and:

> the extent to which any organisation such as the NHS represents a pressure group for maintaining the inherited pattern ... In terms of the medical profession's ladder of prestige, the specialties in the long stay sector were at the bottom of the hierarchy ... similarly the consumers of these services were ... those least able to articulate their demands.
>
> (Klein, 1989: 80)

This second perceived weakness could be classified as an **organisational** problem. The first weakness he outlines (lack of central control) does suggest why some districts were able to take a 'back seat' in policy implementation, but it still does not tell us what motivated certain districts to take those first early steps towards community care. Sir Keith Joseph had a slightly different perspective on the medical lobby, as he stated in 1973: 'No one can see better than doctors the needs of the public and the shortcomings of the service. I am not aware that there has been steady, powerful, informed medical pressure to remedy the real worst shortcomings.' (Joseph, 1973: 561-2). His charge was of indifference. Even more recently, many of the barriers cited in some areas, such as poor estate, medical fragmentation, isolated institutions and uninterested regional health authorities (Pettigrew et al, 1992) appear to have been used as levers for change in other areas (for example Exeter, 1981-1983).

This introductory analysis of the background and history to mental health services in the UK has uncovered reasons behind the delay in service development which appear to be predicated on a number of assumptions about 'barriers'. Hardly any of the writers on mental health care policy take into account the earlier delays and reversals that seem to be part of the mental health services legacy from the past. All of the structural, economic and organisational barriers cited have not prevented certain areas from achieving significant and early policy success. Thus, it is possible to contend that the structural, economic and managerial barriers, whilst being significant, do not tell us the whole story. We also need to consider the background and purposes of the policy making process, as well as examining what happens as policy is implemented and reshaped locally: who the key players and personalities are, and how deep the levels of power and vested interest are in this process of service development. Chapter Three explores some of this background and purpose of policymaking, as well as developing a framework that we can utilise to gain more insight into the policy process at its different stages and the actors involved in policy at different levels. This framework attempts to take into account aspects such as power, rationality and interests in varying degrees and provide the basis for an exploration of *how* mental health policy making in the UK has unfolded over the last thirty years and the *reasons* behind the success or otherwise of different policy measures over this period of time.

CHAPTER THREE:
DEVELOPING A CONCEPTUAL FRAMEWORK FOR STUDYING MENTAL HEALTH POLICY

Introduction

This chapter develops a structure for the exploration of mental health policy making in the UK. This structure is constructed in four parts. The first part (3.1) considers the different approaches to the study of policy making and argues a case for a broadly linear approach, with the attention focused on three main *stages* of policy making: policy initiation, policy formulation and policy implementation. Despite its drawbacks, a linear approach enables the researcher to understand the interactions between the various parts of policy making as they occur. The chronology of policy making, occurring as it does in real time, is important to preserve, to avoid attributing effects to irrelevant causes. The second part (3.2) of the chapter explores where policy making occurs in an organisational sense, and suggests three *levels* where most if not all of the activity takes place: a Macro, a Meso and a Micro level. The third part of the chapter (3.3) charts the possible *dynamics* between the stages of policy-making through the use of Venn diagrams. The Venn diagrams help to illustrate how policy that is implemented may not always be a subset of policy that has been formulated. It also shows that policy as it is implemented can 'spill over' into areas hitherto unexplored in the policy initiation framework. The fourth part of the chapter (3.4) maps out the *relationship* between the stages of policy making and the organisational levels in which policy unfolds through the use of a matrix. This matrix is a very important part of the research, as it forms the structure for the thesis. It points the way to very clear choice of research methods in that it both directs attention to specific locations and actors and frames the research questions that need to be answered for a fuller understanding of policy making in UK mental health services. The conclusion to this chapter outlines the research questions that emerged as a result of this matrix, and sets the scene for the following chapter on a research strategy.

3.1 Stages of policy making – a linear approach

This research aims to unearth how policy unfolds in the field of mental health. It is useful to start by considering the wider study of policy (policy analysis) to see where this study of mental health policy can be located. If policy analysis is about 'the public and its problems' (Dewey, 1927 in Parsons, 1995:xv) then mental health policy would lie right at the heart of this definition. Mental illness is not just an individual illness, but a public problem because of the way it impinges on other individuals' lives. When policy analysis is defined as 'what governments do, why they do it and what difference it makes' (Dye, 1976:1) the study of mental health policy will touch directly onto most of these activities. However what this research does not include is an evaluation of the outcomes of mental health policy initiatives. This study of the unfolding policy process stops at the point where policy is delivered, and so it is fair to say that it does not consider the 'difference' that policy makes on individuals. Impact analysis is outside the boundaries of this research. The concern with mental health policy then is to do with the definition of public problems, the way government reacts to these problems and why government behaves the way it does. For this purpose, the definitions of government will include officials (civil servants and managers) working in many areas and fields rather than just focusing on politicians. Because we are examining how a cross- party policy (Care in the Community) has unfolded over a period of over fifty years many of the actors involved have outlived politicians and parties; much of the policy failures or successes will have at least as much to do with officers and structures as with politicians.

Having defined the parameters of the research within the discipline of policy analysis, in order to examine how mental health policy making works, it is helpful to decide on what we mean by policy. Policy has been variously described as a 'course of action or inaction' (Heclo, 1972:85), a 'web of decisions that allocate values' (Easton, 1953:130) a 'set of inter-related decisions' (Jenkins, 1978:15), a 'stance' (Friend et al, 1974:40). All these definitions suggest that the whole concept of policy is an elusive one.

However, in the case of mental health policy I propose to define the core of this as *stated intention by government.* This might be expressed through written White Papers, party manifestos, or other policy documents, or orally through announcements made by ministers in Parliament and, through the media, to the general public. From this we can work backwards to examine what lies behind the stated intentions, and work forwards to see how policy is implemented. The 'stated intention' provides an identifiable point in an otherwise confused process. It also preserves the chronology that is so helpful in keeping the research rooted in real time. The overarching mental health policy that is examined through this research is the policy of care in the community. However there are other sub policies that are also examined, as we shall see in Chapters Five and Six. It is important to consider the way these sub policies unfold as their progress, or otherwise, can be quite different from the overarching policy.

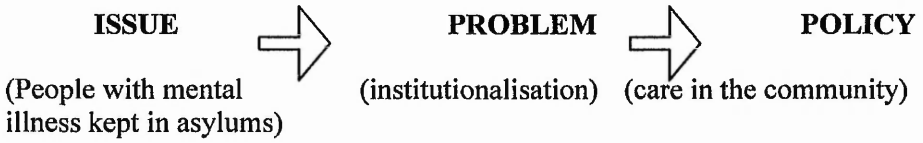
The decision to define policy as *stated intention* and to look backwards as well as forwards from this point drives the research towards a broadly historical approach in the study of mental health policy making. There are exhaustive lists of possible stages of policy-making (see Gordon, 1977; Hogwood & Gunn, 1984, for example) but the three stages of policy making that encompass most of the important activity are *policy initiation, policy formulation and policy implementation.* Our definition of 'stated intention' will lie roughly in the middle of these three stages. Whilst there are some well recognised disadvantages in taking a linear approach to the study of policy making, particularly that of missing any iterative activity between the stages, it is possible to include mechanisms for mapping such interactions through the use of Venn diagrams which will be explored further under section 3.3. Before this exploration, it is important to describe exactly what the three key stages of policy making might include.

3.1.1 Policy initiation – old sins have long shadows

It is unclear where policy originates: as a policy is *formulated*, we can see who is involved in that stage, and as policy is *implemented* we can also note which actors are involved. We can even examine a stage between policy-making and implementation, as policies harden and develop momentum, which we can call the policy adoption phase. But all these stages have to follow on from a much earlier period when the ideas, concerns, priorities and problems emerge in a less overt way. In much of public services the arena for explicit policy formulation will be at the top of an organisation – ministers and civil servants 'craft' policy as a response to a problem, or more proactively, to shape the way that a country functions. The arena for policy implementation will be quite different, and will involve managers who are very close to service users or the public as they deliver their service. Thus it is possible to find organisational locations for these policy stages; even when the top of an organisation consults about the detail of policy formulation it will be a coming together of the top and the bottom of a service, or the centre and the periphery of an organisation. Specialists will be seconded, experts will be called in, and a whole stream of actors process into the policy theatre. Despite all this coming and going, consulting and agreeing, deferring and withdrawing, the final result of the policy that is written will be embodied in a White Paper, with ministerial responsibility legitimating this process. Every meeting that takes place, every consultation exercise, every think tank, will be minuted, - they are official and it is possible to track who attended, who spoke, who represented which interest group and who chaired and shaped the discussions. Now it would be naïve to assume that all the important interactions were captured on paper, for posterity and for analysis, but it would not be impossible, through observation, attendance and discussion, to draw some reasonable conclusions regarding the key actors, agendas, successes and failures of such a process. In short, the policy formulation process takes place within reasonably defined parameters of time and location, and has a clearly visible and defined end product- a stated policy. But if we believe that policy formulation is not the beginning of the process, and that there are important

stages that precede this step, examining who gets involved, how the scene is set and how the policy 'issue' is defined in the first place is going to present formidable challenges. Fortunately, many previous researchers have paid attention to this pre-formulation stage – often referred to as *policy initiation.*

Policies are usually preceded by the 'recognition of a problem' (Parsons, 1995: 87) and those who identify and define the 'problem' will shape the 'initial terms in which it will be debated' (Jones, 1971). But even problem recognition does not take us back to the beginning of our story. More neutral 'issues' trigger problems. People who do not live in houses would not be seen, *per se,* as a 'problem' – but defining this state as 'homelessness' would indeed create a defined, measurable problem, which would then have to be solved by 'somebody'. In the field of mental health there are many 'problems' that have been defined from earlier 'issues', and an example of this would be as follows:



Model 5.1

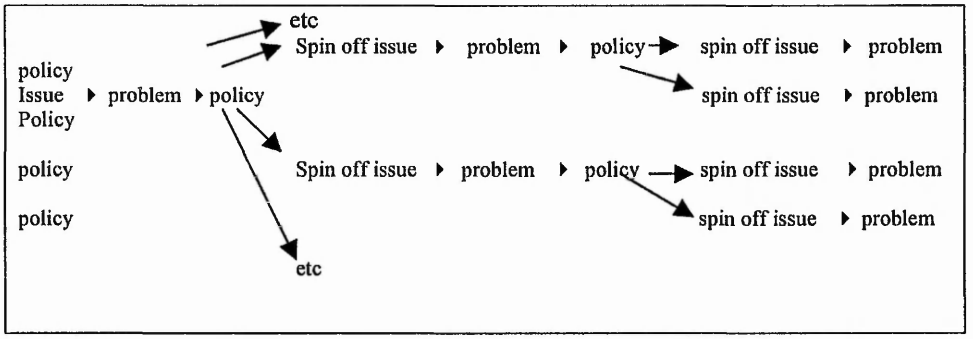
There may be consensus about the issue, but less agreement as to the exact nature of the problem and even less agreement as to what policy should be pursued. The concern about institutionalisation of the mentally ill began in the 1950s in Britain, and it is reasonable to assume that prior to this period, locking people away for the rest of their lives was not seen as a 'problem' at all. Quite the reverse: the very process of institutionalisation was perceived as the answer to a preceding problem (what to do with the mentally ill) and so we can see that problems have to be defined, structured, and placed in a context. All problems will spring from issues, and these, particularly in the case of mental illness, can emanate from earlier attempts to solve related or unrelated

problems. An example of a spin-off problem in mental health would be when the community care policy created a group of people who were available for work, rather than classified as 'ill' and who subsequently contributed to the unemployment figures.

We are beginning to see that past actions have significant effects, both on future policies and on subsequent negative spill-overs into other fields: *old sins cast long shadows*. This cyclical approach is difficult to break into, but regardless of where we start or finish, a section of the chain might look like this:

Issue ►problem► policy ► spin off issue ►problem► policy ►spin off issue

But it would probably be even more complicated than this, because there could be more than one spin off issue as a result of preceding policy, and so our chain might look more like this:



So, the 'doing nothing' option seems feasible and compelling – the first problem might not be solved, but the final four problems might not exist either. Unfortunately the need for politicians to be seen to be 'doing something' is almost overwhelming, so this is rarely an option that a politician would overtly take. But if we return to our original chain of issue – problem -

policy, how an issue turns into a problem, and how the problem is defined is going to be 'crucial to the way in which a policy is addressed to a given problem' (Parsons, 1995: 88). The type and content of policy that gets formulated will be directly related to the initial problem definition.

If we wish to explore this journey from issue to problem, we are really trying to establish whether particular mental health issues are likely to reach the policy agenda. There are a variety of factors that may affect this issue progression, and these will be considered in Chapter Five. Whilst these factors make a good start in assessing how issues turn into problems, individual actors can also get caught up in policy initiation, and the way they influence and set agendas is also important in this respect. This agenda setting process has a lot to do with power. The way different actors control and influence the policy agenda at different levels of the organisations concerned over time can be considered by looking at pluralist as well as anti pluralist models of power. Different models tend to fit at different times, though we will see that the role of the Meso level has historically been very important in this area of individual influence and action.

Although agenda setting has much to do with power and interests, it also has a lot to do with ideas and knowledge. The two are not mutually incompatible, and in fact we will see that historically professionals have drawn power from their knowledge and expertise. The relationship between power and knowledge will be explored in more detail at the different levels in which policy-making occurs. There are many approaches we can take when assessing how ideas influence the policy process, but the following three cover most of the literature on the role of ideas in the policy process.

Hall (1989) discusses the power of institutions to absorb and incorporate ideas into the policy process. He considers that ideas are not the only factor in this process. For ideas to be 'adopted' as policy they need a 'good fit' with economic circumstances, they need to be in the interests of dominant political interests and they need to point to policies that are feasible administratively.

Coats and Colander (1989) were interested in how ideas spread and posited three models for this process: the infectious disease model, the market place model and the information theory model. The first model assumes that individuals can be popularisers and propragandists of an idea, weakening individuals and groups to make them more receptive to new ideas. The second model suggests that ideas are available in a market place for people to trade. The third model assumes that ideas flow in a similar way to information, that there are encoders and receivers, with feedback, and all the resultant problems such as weak signals and de-coding of ideas. Establishing a fit between these three models and the way mental health policy ideas are transmitted will depend on a number of assumptions. The first model is broadly qualitative in nature and stresses the important role of the individual, whilst the second model carries a host of neo-pluralist assumptions, particularly regarding the free availability of ideas and the ability of individual actors to exchange them. The third model is rather mechanistic, focusing on linear processes and barriers. They all have their strengths, but the first model is particularly helpful in the consideration of mental health policy, because of its attention to the role of individuals and because of the way it deals with power as well as ideas.

Network and community approaches focus on the way in which policy communities press for ideas in given policy areas, and these communities have been termed 'advocacy coalitions'. (Sabatier, 1987,) The success of such communities varies. Social science in general and mental health in particular tends to have less 'certain' knowledge than natural sciences (Haas, 1990) and these groups tend to lack 'policy brokers' who can inform 'political consumers of knowledge' of the relevance of their findings. The generally disjointed nature of mental health networks, the lack of certain knowledge and absence of power brokers in this field point to limited agenda setting abilities in these mental health communities, though we may find a few significant exceptions to this.

The above approaches to ideas in the policy process will be considered in more detail at the Macro, Meso and Micro levels in Chapter Five. Policy initiation is therefore much concerned with power and knowledge, and a key component that brings the two themes together is that of professionals and their very different roles in policy initiation at different levels. The exploration of policy initiation would be incomplete without considering the use of language and the way policy actors talk about their policy ideas. When analysing public policy, there is an instinctive urge to focus exclusively on the actions and activities of government rather than on the 'rhetoric'. But researchers attempting to unearth how policy works in the UK without reference to the 'message' may miss important clues that link back to previous themes covered such as power, ideas and professionals. The use of language therefore will be considered in order to fill in some of the important pieces in the policy initiation jigsaw. It is helpful to consider how language is used by actors in the policy initiation process last, as it builds on many of the preceding themes.

In mental health services, policy is initiated all the time. But the over-arching policy issue that has dominated the mental health service for the last forty years, is that of patients being detained in hospitals and the consequent problem defined as institutionalisation. How the issue translated into a problem at the Macro and subsequent Meso and Micro levels is the subject of Chapter Five. Whilst this issue is undoubtedly the 'big' issue in mental health, other policy issues that have emerged more recently at the Meso and Micro levels are also examined. This gives some breadth to the research and allows us to explore whether the process of policy initiation is the same for different levels, and whether the process is the same for different policy issues.

The stage of policy initiation then is largely characterised by problem identification and agenda setting. It sets the agenda very powerfully for the next stage in this process, that of policy formulation.

3.1.2 *Policy formulation: 'I was in a warm bed and suddenly I'm part of a plan.'*

(Woody Allen in *Shadows and Fog*)

Many mental health workers as well as politicians can identify with the above sentiment. Plans and policies seem to appear from 'thin air' and tracking how policy is formulated, whilst less confusing than policy initiation, is still a challenging task. The end of policy initiation has been pinpointed to when an issue has been re-defined as a 'problem' by people who have the power to formulate policy – as a minimum being politicians and civil servants. For the purposes of this research, the end of policy formulation is when a policy *begins to be delivered.* This is a very wide definition of policy formulation, which can take into account numerous policy changes between the Macro, Meso and Micro levels. There are many ways of viewing how policy might be formulated, and I have selected three contrasting perspectives. Policy could be viewed as a rational process, it could be seen as a response to individual interests or it could be viewed as a reflection of the organisational culture within which actors operate. From the first perspective, we could view policy formulation as an *output* of purely rational processes. From a second perspective we could view it as *driven* by individual interests. From a third perspective we could view policy formulation as being *shaped* by the organisational culture. I have specifically selected three key words to sum up these different views: *output/ driven/ shaped.* The first word indicates that policy arrives as a product of a rationale. The second word indicates that policy is presented as a set of pressures and forces. The third word indicates that policy might unfold in a more fluid and less tangible way. In most complex public service organisations, we might see evidence of all of these at different times and in different circumstances.

Identifying characteristics that fit particular examples can assist in explaining how policy formulation works in mental health. Policy formulation may not always happen the same way in all cases over time, or indeed at different levels, and it is important to note which perspectives on policy formulation

appear to fit best in the different circumstances. How can we identify the characteristics that will tell us whether policy examples fit into the varying perspectives? Each of these views on policy making can be broken down into a series of questions to assist in assessing whether an instance of policy-making fits that particular perspective. So to interrogate the view that *policy is a product of a rationale* we are establishing whether the process of policy making, the actors concerned and the mechanisms they use are rational. We can develop structured questions that can be used to interrogate data in a number of policy-making cases, at a number of levels in the organisation. This will enable us to compare results across time, distance and hierarchy. To test the viewpoint that *policy is a selective response to individual interests*, we are establishing whether actors' emotions, feelings and values affect their policy work. To test the view that *policy is a reflection of the organisational culture,* we can consider the formal and informal structures in organisations and social structures between people in those organisations, and analyse how these structures assist actors in gaining influence in the policy formulation process.

The policy formulation stage, then, is characterised by making overt policy choices, by crafting a response to a perceived problem that paves the way for the assumption that someone, somewhere, will implement this policy.

3.1.3. Policy implementation: Literal implementation is literally impossible.

(Majone & Wildavsky, 1978)

I have argued that the process of policy implementation starts when policy begins to be delivered. This does not mean however that revisions are not made to policy during or after delivery. Thus the dividing line between policy formulation and implementation is very blurred, in fact it is possible to argue that the stages overlap. But if we start by identifying what policy implementation is all about, it should be possible to highlight the areas where overlap can occur.

It is no longer fair to suggest that the study of implementation is neglected. Over the last twenty years significant attention has been paid to this important part of policy- making. The growing interest in the study of how policy might be implemented has yielded almost as many models as policy formulation. However, it is possible to plot these on a continuum ranging from a rational *top down* approach to the street level *bottom up* approach, with various possibilities in between. No single model is likely to describe all mental health policy implementation, but different models tend to fit different times and circumstances.

Whilst the fluctuating models reflect much of the history and complexity of mental health policy implementation over the last forty years, they do not necessarily help us to understand why some providers moved more quickly than others. Part of the reason for this deficit is that the models tend to conflate policy formulation with implementation. When we apply the implementation models in Chapter Seven, much of the evidence covers old ground examined in Chapter Six under formulation perspectives. So we can expect that there will be some parallels between the two chapters. However, there are also various arguments in the literature on how to assess the relative *difficulty* or otherwise that actors might experience in implementing policies, and these can be usefully divided into operational, resource and structural difficulties, (Chase, 1979). This is dealt with in detail in Chapter Seven and does begin to answer this thorny question as to why some provider units moved faster than others. Operational difficulties focus on the practical aspects of implementing services for users, and include information collection and knowledge challenges. The resource difficulties do not merely focus on funding and budgets, although they play an important part. They also include personnel and space / infra-structural problems. The 'sharing authority' difficulty is perhaps the area that has affected managers the most, more recently. It is probably the most complicated to measure. We can count the number of agencies involved in delivering services, but it is also important to consider their relative powers in affecting policy implementation. It does not merely mean a consideration of the agencies involved in provision of services,

but takes into account pressure groups locally and the role of the media as well. These difficulties go a long way towards explaining why there are such marked historical differences in implementation, though they may not fully explain the 'early movers'.

Now that we have defined three stages of policy making, we are in a position to apply these to the mental health policy process in the UK. Whilst any amount of mental health policies have been initiated, formulated and implemented throughout the last century, we can take as our main example the whole process of transfer from institution to community care.

- *When did policy initiation first begin*?

This is probably the most difficult question to answer, but the short answer is that when ministers, officials and the public became concerned about the state of psychiatric institutions we can say that policy initiation really got onto the public and political agendas. Something 'had to be done.' This could be pinpointed down to 1950 when the then Secretary of State for Health, Aneurin Bevan, warned his Cabinet colleagues that scandal was likely to break out over the conditions of psychiatric institutions. (Klein, 1989).

- *Where did policy initiation end and policy formulation begin*?

I consider that the 'imperative to act' (Levin, 1997: 42) came nineteen years later, in 1969, when Crossman published the uncensored and damning version of the Ely Hospital Enquiry and appointed the Hospital Advisory Service to inspect and monitor conditions in psychiatric institutions. The issue had become an identified problem, and a policy had to be formulated to solve this pressing problem. However this was still an early stage in a long journey towards community care.

- *When did policy formulation end and policy implementation begin*?

In this context, I think it is reasonable to infer that implementation only began as the very first hospitals began to close their doors and build up community services. This early start to implementation began in 1985. And so we have the parameters for this research with the following three important dates:

1950 Policy initiation - *concern, something must be done*
1969 Policy formulation – *the imperative to act*
1985 Policy implementation – *hospitals close, policy becomes action*

The hopes and fears of Bevan in 1950 took thirty-five years to be addressed, and fifteen years after that we can still see significant differences in the way plans have been implemented. There are other, more small-scale examples of policy initiation, formulation and implementation that we will be examining but they all fall within the wider parameters of the 'big picture' described above.

Having argued that a broadly linear approach to policy making in mental health services covers the timeframe that is necessary for an examination of mental health policy, the next section in this chapter considers where policy making activities are located and carried out.

3.2 Where does mental health policy making occur?

The policy forum for mental health has all the range of actors and complexity of action that one would expect in a modern public service. However the levels at which policy-making happen, in all its stages, can be broadly classified under three headings. These three levels are important to define, not just because of the activities that occur within them, but because of the interactions (or lack of) between them. What is also helpful about this hierarchy is that it enables us to locate the role within which people are operating regardless of their background or job; it is the level at which they are operating at that time that enables us to classify their activity and impact.

MACRO level: this is the national level of mental health policy making, and includes ministers, civil servants and other pressure groups who have an interest in policy making at a national level. This is located at the Department of Health, the NHS Executive Offices in Leeds and London and related organisations such as the Executive outposts across the regions.

MESO level: this is the bridging level of policy making which receives policy from a Macro level and amends, negotiates or adjusts it (or not) before passing it down to the implementers. This is located at district level, through the DHA/ commissioning teams.

MICRO level: this is the implementing level of policy making which receives policy from the Meso level and amends or adjusts it in the course of implementation, with feedback into the national level of policy making. This is located at the provider level, either hospital and/or community based service.

Whilst there will be some overlap, and we are very likely to see the same people crop up in different levels, it is not the individual who is important to my argument, but the level at which they are operating – Macro, Meso or Micro. For example a nurse specialist who provides mental health services will frequently be asked to discuss contracts for services with the DHA – at a Micro level. But the same individual may also be seconded to provide epidemiological advice and support to a district wide working party on mental health services – at a Meso level. Finally the same individual could be seconded to advise ministers and civil servants on current developments – at a Macro level. Even clarifying the location for a multi-role general practitioner is quite straightforward, using the above hierarchy. When a patient with mental health problems consults a GP, the GP is operating at a Micro level. When chairing a local commissioning team the

same doctor is operating at a Meso level, and when 'sharing good practice' at a national conference organised by the Department of Health they are operating at a Macro level. Whilst this upward progression and regression is quite common, the converse is rarely true. We shall see in Chapter Five that officers who are predominantly based at the national Macro level do not tend to operate out of this role, and when they do interact it is almost exclusively with the Meso level. Although the role of the individual is not central in this context, what it does highlight very clearly is that an individual can occupy a number of roles at a number of levels. This demonstrates that actors' abilities to shape policy are not necessarily geographically or hierarchically defined. So when we look at themes for example of power, language or the transmission of ideas it will be important to remember that the levels may be clear (Macro, Meso and Micro) but pigeon holing actors into these levels could paint a limited and incomplete picture. This has implications for research design, which will be discussed in Chapter Four.

Having reviewed the different levels in which policy making might take place, the next section returns to the stages of policy making (initiation, formulation and implementation) and argues a case for viewing these on a continuum. This ranges from a normative 'perfect' model of policy making through a more dynamic approach culminating in a 'fractal' model that propels policy into unforeseen territory.

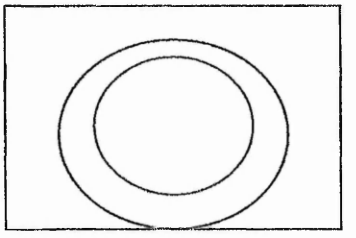
3.3 Mapping the dynamics between the different stages in policy making.

There are a number of ways in which the three stages of policy making can interact, but the three key models that I have developed for exploring these relationships are as follows:

KEY:

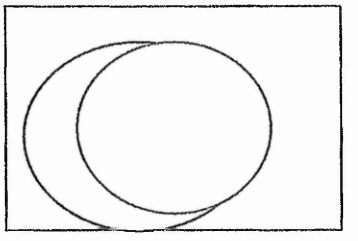
The red box signifies the policy initiation arena, where all options and possibilities are available. The blue circle signifies the policy formulation stage where decisions are made that result in an identifiable policy, as 'stated intention.' The green circle signifies the policy implementation stage where policy is put into practice.

The reductive model: A



In the reductive model, each of the three stages is a subset – closing down options, operating within certain boundaries, reducing choice and constraining growth.

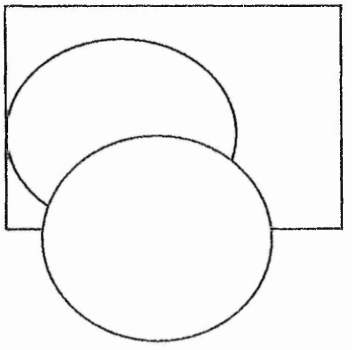
The dynamic model: B



In the dynamic model the implementation stage opens out the policy agenda again, re-visiting priorities and changing agendas, encompassing wider policy initiation areas that had hitherto been discarded – this can be at the expense of

the original policy formulated. The broad framework of policy formulated would be followed, and changes would be in minor areas of mental health activity, either increasing provision in one area or decreasing it in another.

The fractal model: C



In the fractal model, we are operating on the borders of chaos. The implementation stage opens out the policy agenda and also has significant spill-over effects into other policy areas. This fractal model is quite distinct from the previous dynamic model, because of the way that it maps the possibility of implementation affecting other major areas of social policy such as housing, unemployment, public safety and the public's perception of mental health and illness.

In models B and C, policy implementers have significant discretion, power and influence – and not just at a local level. Although the way they implement policy impacts on local people and services, the results have a bottom up effect that can reach back into the heart of central government. These diagrams suggest three different models for mapping the interactions between the stages of policy making in mental health services. In the 'reductive' model A, the policy initiation stage would be a free for all, the formulation stage would be controlled by the Macro level and the implementation stage would be delivered by the Micro level. The Meso level would not be required to do anything. Whilst the first model is a normative one, the other two may offer more 'realistic' views on

how mental health policy is conducted in the 'real world.' The research will demonstrate which models fit best, and we shall see that chronology is an important factor in this respect. The research will also address why there have been such different interactions, and the wider implications of these findings.

So far, various models have been developed and discussed focusing on how policy might work in mental health services. Consideration of the *levels* in which policy making might occur as well as the *stages* of policy making activity that unfold lead us naturally onto a search for a model that synthesises all these factors, and that provides an all-encompassing model within which the research can be conducted. What is the relationship between all the policy activities that have been described and the levels of the organisation within which such activities might occur?

3.4 The relationships between the stages of policy making and the levels at which these activities occur.

Now that we have identified three stages of policy making, and three levels in which policy occurs, how do the two sets of criteria fit together? In other words, what stages of policy making occur at the different levels of the organisation, and what activities might we expect to see in each one? These are important questions because the interaction between the stages of policy making and the levels at which these occur provide the conceptual framework for discovering how mental health policy making actually works in the UK. This interaction of stages and levels helps to locate the 'busy', 'stagnant' and 'unknown' areas for further analysis. In mental health policy making we can demonstrate how these stages and levels might integrate through the use of a matrix:

	MACRO level	MESO level	MICRO level
Policy initiation occurs	?	?	?
Policy formulation occurs	Yes	?	?
Policy implementation occurs	No	No	Yes

We can start with the assumption that the Macro level takes the lead on legislating and formulating policy. There is a formal process and outcomes that can be observed such as government Green and White Papers, election manifestos and public announcements. We can also be very sure that the Micro level implements policy and is the only level that does. We can observe that implementers who fit the B (dynamic) and C (fractal) models (ie for anything less than 'perfect implementation') also shape and change policy as they implement it, and thus are involved in policy re-initiation and re-formulation at a local level, which may have knock on effects at a more national level. But this still leaves gaps in the matrix that need some attention. The most obvious gaps in this matrix are concerned with the Meso or bridging level. We do not know how policy is shaped or changed as it proceeds through the Meso level. It is an opaque box at present. Another gap is the extent to which policy is re-initiated or re-formulated at Micro level. Finally what this matrix does not tell us is the amount of power that is wielded at each level – and the picture is further complicated by the fact that although there is only one Macro group, there are many Meso groups and a multitude of Micro groups operating. Hence it is important to be able to distinguish between *general* rules and relationships that affect every group, and *specific* rules that affect a single group. What we have discovered from drawing our conceptual framework is that the 'busiest' area appears to be at the Micro level, and the 'unknown' area with the most questions is the Meso level. Is it a vacuum, or is there significant activity going on in this

bridging level? If there is substantial activity, how does this impact on mental health policy, both downwards to the Micro level providers and upwards to the Macro level?

Conclusions

In this chapter, consideration has been given to the *stages* of policy making that are most appropriate to examine in mental health policy-making. The policy making process has also been located at three different organisational *levels*, and the types of policy activity that could occur at these different levels has been mapped through the use of a matrix. The matrix provides a framework for carrying out the research, in that it identifies the policy stages and flowing from this the themes that need addressing. It also provides organisational locations or levels in which to collect the information. The themes that need attention dictate to a certain extent the methods for both data collection and the analysis. These can now be broadly broken down under the three key stages of policy making.

Examination of *policy initiation* will be covered by paying attention to the way in which issues turn into problems, the role of agenda setters and the way that they exert power, and the role of ideas and professional knowledge. These themes can be expressed as a series of research questions:

* *How do issues turn into problems?*
* *Who sets the agenda at different levels of the organisation?*
* *How do ideas influence policy?*
* *How do professionals get involved in the policy process?*

Examination of *policy formulation* will be covered by considerations of rationality, individual interests and organisational culture and can also be expressed as research questions:

* *How rational are actors in the policy process?*
* *How do actors' feelings, interests and values affect their policy work?*

* *How do formal and informal communication channels assist actors in gaining influence in the policy process?*

Examination of *policy implementation* will be tackled by consideration of discretion, freedom and choice, as well as an analysis of the varying difficulties which managers experience when attempting to implement policy and can be expressed through the following research questions:

* *When has policy implementation been top down and why?*
* *When has policy implementation been bottom up and why?*
* *What other approaches can be evidenced and in which circumstances?*
* *What difficulties have managers experienced in implementing policy?*
* *Is there a relationship between the difficulties experienced by managers and the methods of policy implementation they adopted?*

The following chapter considers the research strategy adopted in more detail. Subsequent chapters are arranged using the above matrix as a guide: Chapter Five considers policy initiation at the Macro, Meso and Micro levels, Chapter Six considers policy formulation at the same three levels and Chapter Seven considers policy implementation at the Micro level. Chapter Eight reviews all the findings and considers the wider implications for UK policy making.

CHAPTER FOUR:
RESEARCH STRATEGY

Introduction

There are real challenges in researching policy activity in public services generally and in mental health services in particular. Whilst the public sector may be generally well documented, there are usually problems of access and much of the decision making processes are conducted informally. This is particularly the case in the policy initiation stage of policy making, as we have noted in Chapter Three. But even in the policy formulation and implementation stages much of the arguments, the pressures and the individuals concerned may remain unknown features to non-participants. A complication when researching mental health policy is that the actors do not necessarily fit into one particular level of the organisation: they have fluid and changing roles and responsibilities, and tracking this movement is important. A further complication to researching the Care in the Community policy is the time span involved: from 1950 to the present time. This immediately ruled out a number of research methods for delving into the more distant past. Many of the actors were no longer alive and events that had been recorded could not be checked with current policy actors. The research idea was germinated back in 1983, and data has been amassed in real time during this period, but before then any data collection would have to be undertaken retrospectively.

Given these constraints, research design was very important. It was decided that a broadly qualitative research approach would be most appropriate, bearing in mind the policy themes involved such as power, knowledge and ideas. Quantitative data collection however would supplement this where possible, for example the examination of spending plans and the measurement of time allocated and spent on various agenda items at meetings. Whilst there has been much debate about the authenticity of quantitative data, (Gill & Johnson, 1991: 32) and the reliability of qualitative data (Silverman,1993) a multi method approach to the research seemed to be a sensible choice. By

gathering information from a variety of sources and using a range of methods, it would be possible to build up a picture of reality 'out there'. It was decided that a comprehensive strategy should be attempted involving seven components: literature surveys, documentary evidence and analysis, structured interviews, observation at meetings and seminars, quantitative analysis involving weighting, questionnaires and participant observation. How these were selected and how they triangulate are discussed further at the end of this chapter.

4.1 Scope and the thematic approach

With regard to the scope of the research, it was decided to examine the Macro level (that is the Department of Health), but also to include some analysis of a Macro level pressure group that operated independently of the Department. Paying attention to pressure groups at the Macro level would assist in establishing their involvement in policy making, particularly the shadowy stage of policy initiation.

The Meso level was a more difficult area to examine because of the plethora of district health authorities (DHAs) in the UK. However, certain DHAs would be more fruitful to investigate than others – for example the first DHA to close its psychiatric institution was an obvious contender. (DHA1) For comparison, it would also be interesting to analyse a DHA that closed its institutions later (DHA2). I was very keen to examine how the purchaser / provider split and the NHS internal market had affected more recent policy developments, (DHA3) and finally I wished to see if the advent of a new Government had changed policy in the last three years (DHA4). To tackle the problem of access, I selected four DHAs which I had either worked in as a NHS manager, or could gain access to as a lecturer/ researcher. This enabled me to gain access to a significant degree to the staff, meetings, paperwork and cultures in real time in DHA3 and DHA4, and retrospectively to interview staff in DHA1 and DHA2 where I had formerly worked. The four DHAs and the chronological events examined were as follows:

- DHA1: the 'early mover' in Exeter (1981-83)
- DHA2: The 'later mover' in South Derbyshire (1988-2000)
- DHA3: the 'contract culture' in Nottingham (1996-98)
- DHA4: 'under New Labour' in North Cumbria (1998-2000)

An advantage of interviewing retrospectively in DHA2 was that I gleaned information across the twelve years up to the present time. The protagonists were still in the same posts, and were able to take the 'long view' of events. This enabled me to use DHA2 as a comparator with the later DHAs in Nottingham and North Cumbria. The staff in DHA1 had moved on, and could not provide this perspective. An alternative approach to the study would have been to examine one DHA over this period of time. The advantages of progression would however have been outweighed by the lack of a comparative approach. The aim of the research was focused on how policy develops, and why it develops differently in different districts. This could only be addressed by examining a range of contrasting DHAs at the Meso level.

The selection of provider units at the Micro level flowed directly from the identification of the Meso level DHAs identified above. The provider units in these DHAs formed part of the research inquiry to follow through unfolding policy events, most importantly policy implementation. These units are identified as PROV1, PROV2, PROV3 and PROV4. PROV1 (Exminster Hospital) was one of the first institutions to close in the UK, and community mental health services were re-provided for the ex-patients in a neighbouring health authority (Torbay). PROV2 comprised two hospitals (Pastures and Kingsway) with consequent re-provision of services in the County of Derbyshire from Pastures Hospital and in the City of Derby from Kingsway Hospital. PROV3 was a fairly mature community mental health service, with a vestige of services based in the old hospital buildings of Highbury in Nottingham. PROV4 was also a fairly mature community mental health service in North Cumbria with vestiges of the service still based in the old Carlisle hospital, now renamed Carleton Clinic.

It will be clear from the above discussion on scope that the research approach would be broadly based on a comparative series of case studies. There are significant benefits to a multi-method research design for such an approach (May, 1997). The choice of case studies, based on a range of political and structural factors, lent itself particularly well to a theoretical sampling approach (Glaser and Strauss, 1967). By researching in DHAs and units that had very different experiences of policy activity, it would be possible to learn about the many issues as they emerged in each of the DHAs concerned. It would then be possible to identify key themes that merited further exploration, through further interviews, or other fieldwork. Although it is not possible to generalise from these results, particularly at the Meso and Micro levels, the reasons for the structural patterns that existed and the reasons that lie behind certain policy decisions may be relevant in other settings. The value of a case-study is that it identifies the relevant actors and the salient variables which might affect the outcome of a policy initiative. In the case of these four studies we are led to the conclusion that there was nothing special at all about the 'early mover' hospital, but there was about the Meso level actors above them. This may not be the case in other DHAs, but the generalisation that the relationship between the Meso and Micro levels must be taken into account is still valid. Whilst the 'early mover' case study was probably an unique one, the other three may or may not be typical of other DHAs. The typicality or representative-ness of the findings is less important than the ability to open up the issues and lay bare the implications. This use of case studies to develop and challenge emerging concepts has been well documented by researchers on theoretical sampling such as Glaser and Strauss (1967). The general factors which existed in all four could operate across geographical and agency boundaries. As Dunleavy argues:

> The typicality of the cases selected is dissolved as a problem since we hope to detect a logic of action involved in policy development, to establish the existence of structural relations which can be taken to operate in other areas in substantially the same form.
>
> (Dunleavy, 1981a: 199)

There are considerable arguments against a thematic or case study approach however, precisely because of its inherent view that theories can explain actions. Dunleavy's use of the word 'hope' needs a little more attention in this respect. More analytic approaches tend to assume that it is circumstances and mechanisms that explain actions (Levin, 1997). In the analytic approach the test of validity is consistency rather than plausibility, the aim is to collect observations that can be unified, which fit together rather than searching for generalisations. However, it is perfectly possible to study a series of cases, taking a thematic approach, but by asking the same sets of questions in each case, we can generate more consistent comparisons. Levin summarises this approach as follows:

> In studying government and policy making, the equivalent of this approach is to use techniques that take the form of 'heuristics' – sets of questions that we can use for 'interrogating' the phenomenon that we are studying. Each set of questions will be 'rooted' in a particular conceptual framework and the 'perspective' that that conceptual framework provides.
>
> (Levin, 1997: 31)

The primary task then was to frame and structure the correct sets of questions in order to 'interrogate' the data effectively. The first research method that is now discussed assisted in this process.

4.2 Literature survey – or how to ask the right questions

A wide range of literature was consulted throughout the life of the research. The main texts that were used centred on public policy and policy analysis, but also included texts on public sector management and strategic planning. Various clinical and epidemiological texts relating to mental health and psychiatry were examined, predominantly from the UK and the USA, but a number of European mental health publications (Spanish and French) were included to gain a wider cultural perspective. The literature search fulfilled two objectives: it enabled me to gain a historical perspective of mental health services and it suggested a framework for analysing how general public policy works in the UK. In

practice, the literature search informed the empirical research design in two ways. It identified the key themes that were to be addressed under the policy stages of initiation, formulation and implementation. It then provided a series of frameworks for research questions as outlined at the end of Chapter Three. This included examination of policy initiation (How do issues turn into problems? Who sets the agenda at different levels of the organisation? How do ideas influence policy? How do professionals get involved in the policy process?), an examination of policy formulation: (How rational are actors in the policy process? How do actors' feelings and values affect their policy work? How do the formal structures and informal social mechanisms assist actors in gaining influence in the policy process?) and an examination of policy implementation: (When has policy implementation been top down and why? When has policy implementation been bottom up and why? What other approaches can be evidenced and in which circumstances? What difficulties have managers experienced in implementing policy? Is there a relationship between the difficulties experienced by managers and the methods of policy implementation they adopted?)

The questions were grouped under themes drawn from different views on how policy making works. This approach came from Levin's work on social policy analysis (1997), and lent itself particularly well to research which covered such a big subject (mental health policy in the UK) over such a long period of time (fifty years.) Whilst Levin has focused mainly on policy formulation questions, I have extended his approach to include many sub-questions on policy initiation drawn from Hogwood and Gunn's work on issues and problems (1984) and writers on power such as Ham & Hill (1993), Parsons (1995) and Lukes (1974). I have also constructed sub-questions exploring policy implementation based on Dunsire's work on compliance (1978), Elmore's work on backward mapping (1985) Lewis & Flynn's work on institutional context (1979). Hood's work on normative models (1976), Dunleavy's work on the skewed process of policy implementation (1981) and Chase's work on the difficulties of implementation (1979) were also examined. The structured questions were then addressed by

using a wide range of research methods, the remainder of which is outlined below.

4.3 Documentary evidence and analysis

An important research method adopted for finding out how policy actually worked in mental health services proved to be *documentary analysis.* The information that I had to search for included the following: dates that events occurred, attendance at meetings where decisions were made, financial priorities (planned and actual), instructions through the hierarchy, and a plethora of guidance notes and advice letters from the Department of Health and the NHS Executive. This became an important component of the fieldwork, and took significant time. The documents included archive material (internal to the NHS), budget statements (Macro and Micro) and internal as well as external correspondence between actors in the NHS. Documentary evidence was particularly helpful for examining events that occurred in the 1950s until the 1980s. I conducted a literature search that included government White Papers, memoirs of Health Ministers of the time, Social Services Committee minutes, Hansard, Reports from units such as the PSSRU, the National Audit Office and the Audit Commission. I analysed this material by coding it under policy initiation/ formulation/ implementation stages, and the corresponding themes and research questions outlined in the above section on literature search.

4.4 Interviews

The decision was made to carry out semi-structured interviews with key policy makers and implementers, adopting a hierarchical approach, working from the Macro to the Micro levels. The interviews were conducted between 1997 and 2001, but covered events that stretched back to 1983. The top down approach gave me a chance to follow through aspects of policy as it unfolded, sometimes in 'real time', and enabled me to compare actors' comments about policy actions at different levels. This highlighted different views and opinions about the process of policy, although the factual evidence that I collected remained

surprisingly consistent at the different levels and districts. Conflicting accounts did arise when discussing whether and where policy making actually happened. Officials tended to suggest, initially, that policy making was not in their remit, and went on 'somewhere else.' This search for the elusive 'phenomenon' (Silverman, 1993) is well documented, but on further discussion, officials did start to discuss instances when they had been involved in policy formulation. They also tended to underestimate their interactions with the different levels of the organisation. A classic example of this was when I asked the chief executive of PROV2 whether he had any dealings with the Macro level. After stating that he did not, when I questioned him about barriers to implementing policy, he related how he had to visit the NHS Executive outpost in Trent, in order to negotiate an extra three million pounds in capital monies to build up community services. He laughed as he realised that he had just contradicted himself. Actors' comments also enabled me to gain an understanding of the policy and assumptive worlds they inhabited. This was not a static process, in that some actors 'moved around' the hierarchy, even when they occupied the same post. It was important for me to gain an 'insiders' view of this process because I could then begin to map out any differences between working at the different levels of the organisation and also pinpoint what level actors were working at, as they discussed their activities and preoccupations. These differences between levels included cultural as well as structural variations that gave some clues about why policy tended to develop in certain ways at certain levels.

Sixteen officers from health and social services were interviewed, each for 1-2 hours. The interviews were semi-structured, recorded in shorthand and word processed later. The questions were designed to explore relationships between the Macro, Meso and Micro levels, as well as between pressure groups and the statutory services. A list of the key questions asked at *all* the interviews is given in Appendix A. A further two interviews were conducted with managers of pressure groups at the Macro and Meso levels (MACA and MIND) and one researcher in policy analysis, employed by the Queen Mary and Westfield College, University of London, met me for a discussion about mental health policy networks.

Macro level:

The two senior civil servants responsible for mental health policy at national level were interviewed at the Department of Health in Leeds. The Regional Outpost Director with responsibility for mental health in Trent was also interviewed. One head of a mental health pressure group (MACA) at a national level was also interviewed. They were all asked questions relating to the structure of their organisation and their role, relationships with other key groups, how they would define planning and where it was happening as well as any problems encountered in planning, their thoughts on discretion in policy making and implementation and where they thought policy making ended and policy implementation began. A researcher on policy analysis (Wayne Parsons) who had some experience in mental health policy networks very kindly allowed me to pick his brains about the role of ideas and knowledge in policy making, and also gave me some pointers on ways to develop my research matrix.

MESO level

Four health managers responsible for commissioning mental health services within the respective DHAs were interviewed and the focus here was about planning and implementation, relationships upwards and downwards, the effects of pressure groups, the opportunity for discretion, and power, knowledge and information in the policy process. The Director for Nottinghamshire (Mind) was interviewed with similar questions. Two ex-social services staff, now researchers working in St Martin's College, Lancaster, were also interviewed. Here, the focus was more on relationships between the two statutory bodies, key challenges and frustrations in the joint mental health planning process, and cultural and political differences. It was not possible to interview social services staff from the four case study DHAs and so the information gleaned was of a more general nature.

MICRO Level

The four chief executives and three other locality managers responsible for providing mental health services were interviewed with questions based on relationships, power and discretion, and again power, knowledge and advice in the policy process. They were also questioned about the levels of difficulty they experienced in implementing policy, and asked to list the barriers that they had to overcome in order to achieve success. They all discussed their varying relationships with the Meso level, and any contact with the Macro level. They were asked about pressure groups and how they operated at the Micro level, and the role of users in the policy making process.

I have noted that the majority of the factual information that I derived remained surprisingly consistent at the different levels and districts: dates that events occurred, who chaired and controlled the agendas of meetings, who held the purse strings. But the more qualitative evidence gained from these interviews was also extremely important in that I discovered a whole range of informal activities going on, which would never be documented or formalised. For example, when asking Micro level managers what were their 'high' points in their careers, a lot of information relating to status and comparisons with other general hospital managers came out. When asking managers about the 'low' points in their careers, they related examples of disasters and crises that had befallen them at work, and from that I was able to tease out where they went for support and how the different levels interacted during such shock events. I also discovered as I interviewed from top to bottom of the organisation that policy making and planning were considered to be *dirty words* now, but that there was a lot of it *going on:* albeit with some initial confusion about the precise location of all this activity!

4.5 Observation at meetings and in seminars

I attended six meetings at Macro, Meso and Micro levels, which were joint planning meetings at the Meso level, regular policy meetings between the Macro

and Meso level and Micro level planning teams and case conferences. Clearly there were some drawbacks to attending meetings as an overt observer, but one exception is worthy of special mention. It was one of the few occasions where I was a covert observer, and it happened quite by chance. The Macro interview I was conducting came to an end, and I was invited to attend a regular three-monthly national meeting between the Department of Health and all the regional lead mental health officers in England. When I asked my interviewee whether he thought my presence might have an effect on the meeting he suggested that he simply mention that I was 'job-shadowing' him for the day. This I did with some reservations, but the findings of that meeting were extremely valuable, not least for the fact that they occurred in a 'natural' setting. After the meeting, I spoke to members individually and obtained permission to use the information gained for my research.

I also had a number of more informal discussions with approximately thirty clinical and managerial staff, usually in the context of my training and teaching work. On each occasion that staff volunteered interesting information, I asked and gained permission to use this in my research. One such example was where a public health officer attending a management course I was running spoke about the demands for statistics from the Department of Health which the DHA had difficulty in supplying. When I asked her how the DHA coped with such demands, she replied 'We make them up. We call it feeding the beast.' (DHA3.June 1997, personal archives). This is a good example of a piece of evidence that would not normally be elicited through formal interviews or surveys. The context was a training session and the issue under discussion was that of stress and workload.

4.6 Questionnaires

4.6.1 Decision making and organisational culture questionnaires

At the Macro level, both civil servants interviewed also completed rating scale questionnaires on decision making processes (Appendix B) and rules and

formalisation (Appendix C) drawn from Lawton & Rose (1994). These were helpful in assisting me in the discovery of the attitudes and culture that existed at the top of the organisation. This was particularly important in filling a gap, as I had no experience in working at this Macro level. The same questionnaire was completed by the planner in DHA3, for comparison.

4.6.2 Values questionnaire

At all stages of the policy making process, there was the potential for individuals to exert pressure and influence. Behind this pressure lay a number of issues, one of which was that of individual values in the resource allocation process. Whether this was exerted through agenda setting methods in policy initiation, or identification of need at the formulation stage, or through targeting of services at the implementation stage, the potential for actors to impose their values on this process were considerable, but particularly in the policy formulation stage. Without exception, everyone interviewed stated that individual values affected the decision making process in their part of the organisation. Leaving aside personal gain, which might be common to all actors, there were very different definitions of equity in mental health services that would benefit from exploration. A questionnaire was adapted to make it relevant to mental health services (Appendix D). This questionnaire mapped five different definitions of equity, namely deserving-ness (of the client), individual need, utility (the common good), politics (satisfying interest groups) and fairness (equal access to all). Respondents were given the opportunity to grade twenty statements (does /does not express my preferences) on a rating scale of 1-5. These results were be plotted on a chart that would enable comparisons to be made between the Macro, Meso and Micro levels. I wanted to see whether different actors fell into any particular categories, arising from their *position* or *role* in the organisations concerned, and whether this contributed to an argument about discretion in the policy process.

4.7 Quantitative analysis

Although the research was broadly qualitative in approach, two more quantitative methods were also used. The first method was a quantitative weighting of agenda items at three meetings between the Macro and the Meso levels to establish how many items were directed by the Macro level, and how many items were led or shared by the Meso level. The amount of time spent on each of the items was also noted. This information was useful for assessing the relationships between the two levels, as well as any dominance on either side. The agenda items *per se* also indicated what officers at these levels were paying attention to, and therefore considered important. The second method was a quantitative and qualitative analysis of email communications to the Macro level mental health senior civil servant over a period of one week. The number of communications and their subject were noted as well as the senders. This helped me to gauge which were 'hot' issues, and also to map out some of a Macro level officer's network of contacts. As I had no experience working at this level, again this helped to fill in some cultural gaps.

What I discovered from carrying out quantitative analysis is that there is always qualitative information that can be mined from such data; as noted above, the findings did include significant qualitative information such as power relationships and the ways in which officers prioritised their work.

4.8 Participant observation

Researchers who have worked in the field prior to carrying out their investigations start with a number of advantages. Access is often easier, and there is a wealth of information that they already carry round in their heads. Unfortunately, much of this information is not sorted into a logical pattern that renders it immediately useful for analysis. So combining fieldwork with past knowledge is a confusing and time consuming occupation. I discovered that the ten years I had spent working in mental health services had yielded precious little in terms of immediately useful data - the majority of the

information had to be checked again, as it was based on hunches, anecdotes and one-off experiences. Yet I was convinced that the unusual circumstances of my work (as Personnel Officer in one of the first mental illness hospitals to close, PROV1, followed by a position as joint planning officer in a 'later mover' PROV2) would be fertile ground to analyse. Some time elapsed before this problem was tackled, but what was most helpful in analysing much of this information was the use of the structured research questions which I was already developing as a result of the literature search. The analytical process was a combination of memory followed by archival analysis. Attendance at meetings could be checked by the minutes of such meetings. The dates that events occurred could be ascertained by consulting my own and colleagues' diaries (past and present secretarial staff were invaluable for this). Spending plans and priorities were gleaned from internal annual plans both at hospital and district health authority level. There were also numerous minutes of meetings and diaries which I had kept when working as a joint planning support officer for a DHA and social services. This role was I think unique, because I was expected to be both impartial and at times to act as a go-between and a negotiator. The neutrality of my role helped me to stay in 'observational mode. The substance of the discussions and the dynamics of these meetings provided invaluable data for my research.

There was a 'bridging' phase between being an actor and a researcher. The final three years working as a manager were combined with completing a Masters programme at Aston University, and much of the information I collected during this time, both as observer and through archives, provided a good foundation for this later research. The main pieces of research which were most useful included (i) an analysis of how a mental health service wrote its strategic plan (Derby), (ii) an essay on power models and their relevance to mental health services, (iii) a description of the group dynamics in a joint planning forum, (Southern Derbyshire Health Authority and Derbyshire Social Services) and (iv) a comparative dissertation on mental health services in the UK and Spain.

4.9 A contingency approach to coding

I have already intimated that delving into the more distant past was mainly carried out through analysing archival documents, and that discovering informal activities was most fruitfully achieved through discussions and interviews. However, there was a clear difference between analysing how policy *initiation* worked in mental health services, as opposed to policy formulation and implementation. The latter two stages of policy making lent themselves very well to structured questions rooted in various policy perspectives. The process of policy initiation however was distinctly more shadowy. It was very much concerned with issue emergence, power, ideas and knowledge (all very difficult to 'measure'). The method adopted to establish how policy was initiated was therefore developed using a (modest) grounded theory approach (Glaser and Strauss, 1967). This approach can be very useful for examining complex social phenomena, and a range of materials can be utilised to develop theories and hypotheses, that can then be explored. It is neither an inductive nor a deductive approach, but it attempts to combine both. The overall research questions in policy initiation were developed not just from literature searches, but were informed by initial interviews with two officials at the Macro level and exemplify the gradual build up of ideas and information as I carried out initial literature searches, interviewed people, then returned to the literature, before developing more detailed ideas that could then be explored by further fieldwork. The research scope in mental health policy making was far too wide ranging to contemplate microscopic examination of all the data, but certain aspects of policy initiation lent themselves very well to such an approach. The method of grounded theory adopted was *conversational analysis* based on discussions and interviews with actors at the Macro, Meso and Micro levels of the organisations concerned. Transcripts of interviews were coded, using key words spoken by actors as *in vivo* codes initially, and then grouping these under wider axial headings that referred to particular aspects of policy initiation. The five axial headings I chose were based on literature searches, and comprised *issue emergence, agenda setting, power, ideas and language.* I also had a sixth heading, which

was 'any other' to ensure that I was not missing out any key concepts in policy initiation. The *in vivo* codes were often grouped under more than one heading, and by the time I had completed nineteen interviews I had developed a mass of linkages that looked rather like a bowl of spaghetti! There were still gaps which I attempted to fill in using documentary analysis and literature searches, particularly to establish how policy initiation appeared to work in the more distant past. I retained the same axial coding, and also strove to use direct transcripts or reported speeches by actors from that time so that I could use *in vivo* codes to feed into this process. Five examples of *in vivo* coding from interviews/ transcripts and how they were linked to wider axial codes are as follows:

(i) *Scandalous (*Bevan, 1950, on the state of the psychiatric hospitals) issue emergence: crisis

(ii) *Feeding the beast (DHA3, 1997)* negative power

(iii) *It's in your base allocation (DHA2, 2001*) agenda setting: definition of alternatives

(iv) *I'm two telephone calls away from the Minister(PROV2, 2001*) agenda setting: containment of decision making

(v) *We fought fire with fire (PROV1, 1983)* the use of covert power

The 'spaghetti' was untangled initially by separating out the Macro, Micro and Meso evidence (through the simple but expedient method of focusing different chapters on different levels of the organisations). Later on I was able to integrate the levels together, by merging these three chapters into one, (Chapter Five) enabling me to take another look at the wider picture. Using the same axial headings across the three levels of organisation enabled me to compare and contrast quite effectively. The importance of leaving a clear research trail was achieved by these three steps of *in vivo* coding, axial coding and then comparing across the Macro, Meso and Micro levels of the organisations concerned.

Conclusions

The combination of mainly qualitative research methods with limited quantitative data collection and analysis was held together through the broad research questions outlined at the end of Chapter Three and mentioned in 4.1 literature search. The most important part of the research strategy was generating the right questions, and whilst it was not possible to triangulate every single piece of evidence, it was possible to ensure that these key questions were examined from a range of angles. In fact many of the questions formed different perspectives of the key themes to be addressed. Where the evidence was confusing or contradictory, I either carried out further interviews and documentary analysis to gain a wider perspective, or where this was not possible (for example delving into the distant past) I have stated where the gaps and inconsistencies lie. There is a very real world out there with people who have spent their lives making and implementing policy. But the deeper forces that drive these people and shape their minds may be but dimly known, even to themselves.

CHAPTER FIVE:
POLICY INITIATION IN MENTAL HEALTH SERVICES

Introduction: fire-fighting

In this chapter, I shall be examining how policy is initiated at the Macro, Meso and Micro levels. This examination will include consideration of how issues turn into problems at these levels, and one major policy initiation example will be followed throughout the three levels, the issue of *mentally ill people detained in hospitals* and the subsequent problem identified of 'institutionalisation.' A further sub-policy initiation issue, that of *mentally ill offenders*, will also be examined at the Meso level. This example highlights how and when the Meso level is likely to get involved in initiating policy. Whilst the whole process of policy initiation is defined by the metamorphosis of an *issue into a problem* the analysis will conclusively demonstrate that external factors cited by researchers for driving this change do not tell the whole story. In order to ascertain what else shapes mental health policy initiation, attention will also be paid to the role of key *agenda setters* in this process. The methods by which agenda setters control the policy initiation process will be analysed, in particular the ways in which they use different sources and levels of power. The pressure to retain the status quo was so strong for forty years precisely because an anti pluralist approach was adopted by civil servants at the Macro level, and by professionals at the Meso and Micro levels. The assumption that lies behind an anti pluralist analysis is that agenda setters are pursuing specific interests and objectives. However, policy can also be shaped by other factors, in particular the pursuit of ideas and knowledge. There are a number of approaches to assessing how ideas affect policy initiation, and these are variously reviewed and applied to the different levels of mental health services. In practice it is almost impossible to separate out ideas from interests, and I therefore conclude that whilst 'ideas' about policy come first, chronologically, interests are never far behind. What is significant when looking at the role of ideas and knowledge is that one model (infectious disease) tends to fit the 'early mover' activity, whether at Macro,

Meso or Micro level, but that most other Meso activity fits the 'network' model. The Micro level is characterised by a quite different model of idea transmission, that is viability. All these findings draw the researcher towards a hypothesis that it is the individuals rather than the institutions that make a difference when policy undergoes a radical change in direction. In order to explore how these individuals might 'make a difference' we return to the key role of the agenda-setting policy initiators, operating at the deepest, covert level of power propounded by Lukes (1974: 24). A closer look is taken at their ability to shape people's beliefs and wants through the manipulation of symbols and culture, primarily through the use of language. If the Micro level has historically dominated the policy initiation agenda through the use of knowledge and information, the use of covert power has also been widespread. Unsurprisingly, actors wishing to prevent or slow down developments in policy utilised this level of power at the Macro, Meso but particularly the Micro level. Perhaps more surprisingly, the 'early movers' (DHA/PROV1), who had such an impact on mental health policy as their hospitals closed and community services built up, also utilised this deeper, covert level of power. ('We fought fire with fire.') This final analysis of policy initiation in terms of covert power then, explains why the status quo was adhered to for so long, and why actors who did not utilise such powerful tools to shape people's perceptions and beliefs were resoundingly unsuccessful in trying to engineer change.

5.1 How do issues turn into problems at the Macro level?

Sometimes mental health issues get taken up by politicians and civil servants at the Macro level, and other times mental health issues languish or fade away. This difference may be to do with the issue itself, or the people and personalities concerned, or possibly both. So how can we establish whether particular mental health issues are likely to reach the policy agenda? Hogwood and Gunn (1984: 68) outline six factors which may contribute to this progression, and these may illuminate how and why the *issue* of 'mentally

ill people detained in hospital' in 1950 took so long to be translated into the *problem*: 'institutionalisation' in 1969.

The first factor is whether the issue has reached *crisis proportions*. A crisis can be defined as when an issue receives widespread attention by the public and there is urgent pressure for 'something to be done'. In 1950, Bevan spoke of the poor state of the mental health service. In fact he warned his colleagues about the likelihood of scandal breaking out about poor conditions (Klein 1990: 80). But it was not until 1969 that Crossman seized the opportunity provided by the Ely Hospital Report Committee of Inquiry (HMSO 1969) to publish the uncensored and damning version. He then diverted funds into this sector and appointed a Hospital Advisory Service to inspect and monitor conditions in mental health institutions. Our example shows that although the issue had reached crisis proportions in 1950, and was perceived to be 'scandalous' it took nineteen years before action was taken. There seemed to be an enormous gap between the 'crisis' identification and the imperative to act. Why did nineteen years elapse before the 'problem' got onto the policy agenda?

The second factor is that the issue achieves *particularity*, in that it can exemplify and dramatise a larger issue. The larger issue or principle arising from ill treatment of patients in asylums is that of *institutionalisation*. This is the process whereby people who are admitted to hospital for long periods of time lose the freedom and motivation to have control of their own lives and to exercise choice and autonomy in the way they live. This larger issue, by default, defined the problem.

The third factor is that the issue has an *emotive* or human-interest angle. Most areas of social policy can be argued to have a human-interest angle in that they may have ramifications for the everyday lives of the public. About ten percent of the population suffers from mental distress at any one time (British Mental Health Foundation in Ramon, 1996:10), everyone knows friends and relatives who might be suffering, and so it touches all our lives.

The fourth factor is that the issue seems likely to have *wide impact.* The number of asylums in poor condition was growing; 'Some of our mental hospitals are in a disgraceful condition' (Bevan, in Klein, 1990:31). The number of reports into psychiatric hospitals were growing, and although the findings were neither fully nor promptly made public, there was still a growing unease at least at the Macro level of the organisation that all was not well in this 'Cinderella sector' as noted by Bevan, above.

The fifth factor is that the issue raises questions about *power* and *legitimacy.* Again, the whole process of institutionalisation and the way patients were controlled and prevented from leading normal lives, raised important questions about the power of the asylums and the legitimacy of staff actions. A patient had no right to privacy, to bathe or be toileted or to sleep alone. They lost the ability to invest and spend money (though they were occasionally allowed 'pocket money' usually earned from menial or low grade work.) They had very little choice about when they slept or ate, what clothes to wear (often clothes were confiscated on admission) and their rights to receive visitors was subject to the decisions of others. These conditions were not imposed for a matter of weeks or months, but for decades, as part of the institutional arrangements on admission until discharge or death. These conditions were not just in place at the early part of the twentieth century, but continued until the late 1980s in some districts. When I visited a psychiatric hospital in 1982, a manager proudly showed me the improvements that had been made, such as the provision of curtains around patients' beds, and a locker (unlocked) for individual patient use. These institutions had become lost in the past.

The sixth factor is whether the issue has become *fashionable* in some way. North American hospital closures in the 1960s (and Italy in the 1970s) provided growing evidence that people with long term mental illness could live outside hospital settings.

The critique of the '*hospital as a social institution'* referred to in Chapter Two had begun.

We can note two points from the above analysis. The first is that many of the factors overlap and inter-relate. The second is that the factor of *crisis* was not by itself enough. The other five factors all contributed to Crossman's final imperative to act in 1969. Even so, these factors alone did not necessarily guarantee politicisation and access to the policy agenda – they were all present by the early 1960s. So what did?

Because people make policy, we also need to consider the important influence and activity generated by **agenda setters**. To examine this area it is necessary to explore who the agenda setters were, and what the extent of their influence was in the policy initiation stage.

Before moving onto to the important role of agenda setters, it is worth considering a more recent example of problem definition. In the wake of the Clunis affair which was generally perceived as a *crisis,* Christopher Clunis stabbed Jonathan Zito on the London Underground in 1994 and Jonathan Zito subsequently died. It was an unusual act of violence committed by a person with a severe mental disorder. The example is an interesting one because it demonstrates how responses to shock events can have significant repercussions for policy making as a whole. Until that point, all mental health policy making was seen to be the province of the centralised civil service and ministers rather than presenting a role for managers. There was no mental health focus in the NHS Executive at all. The mental health lead officer noted: 'In mental health particularly, we had a problem. Until the Clunis affair there was no mental health group within the Executive; there was not the capacity in Leeds.' (DoH.interview1, 14th March 1996). Before 1995, the Department of Health dealt with policy development, managing, creation and briefing support to ministers whilst the executive dealt with transmission of policy downwards, as noted by the lead officer for UK mental health services: 'They (the Department of Health) never bought the idea that management was separate from policy making.' A 'shock event' forced the Macro level to re assess its management structures and responsibilities. Mental health policy and planning posts were created within the Executive, and the Executive was

directed to deal with management **and** policy. However, the downward pressure of responsibility to the Executive and beyond, left something of an accountability gap in the Department of Health itself, perhaps through design rather than accident: 'Now the only political accountability for mental health services is through Parliament.' (DoH.interview1, 14th March 1996). This is also an example of a disaster driven initiative. The government response was to set up Supervision Registers and to introduce a scheme of supervised discharge arrangements in 1995. Supervision Registers were required for all mental health units and comprised a list of individuals 'at risk' of self harm, harm to others or self-neglect. These registers were not accompanied by any additional powers or resources and it is generally agreed that they had no specific benefit to patients, but did add to their stigma (Turner, 1997).

The above example highlights the effects that can occur as a result of responding to a single event, dramatic though it may be. The most senior civil servants in the Department of Health believed that this single incident had taken away a whole layer of political responsibility at this Macro level. Although this is an extreme example, it is not untypical of the way in which policy initiation occurs at the Macro level according to the lead officer for Community Care at the NHS Executive:

> In this Department, there is so much public interest that we tend to be crisis driven, reacting to media and public events. Tends to be reactive, lots of surprises. There is an effort to reverse this, to be more strategic.
>
> (Department of Health.Interview2, 14th March 1996).

From the above example we can conclude that Macro level officers and politicians in the 1990s were driven by two of the factors cited by Hogwood and Gunn, namely *crisis* and *emotive/ human interest*. However, this is by no means the whole story, because we have not yet considered how actors use power and influence to initiate policy. Before we do this, however, we need to consider how the above factors influenced the way policy was initiated at the Meso level.

5.2 Is policy initiated at the Meso level?

Policy could be initiated at the Meso level in at least two different ways. The most common way would be when the Macro level formally invite advice and suggestions from the Meso level. However, discussions with the Lead Officer for Community Care at the Macro level suggested that this process is far from clear. He stated: 'There is a lot of planning activity, not always linked into what actually happens. Sometimes there is a process – reports and guidance comes from civil servants and externally in the field.' ((DoH.interview2, 14th March 1996). When asked about the challenges of initiating policies generally, he also cited the difficulties of getting good local information: 'We don't have enough information to support detailed policy decisions. There are difficulties in understanding how the policies might evolve in practice. Civil servants are not very hands on and field staff also have information deficits.' When asking Meso planners how they get involved in policy initiation at the Macro level, the same lack of clarity is noted: one planner believed that there were: 'enormous ambiguities between national and DHA responsibility. We talk through problems informally on the telephone a lot and share problems and enormous advice quite freely. It's probably not as effective or as rigorous as it should be.' (DHA3.interview, 4th June 1997.)

A second way in which Meso policy could be initiated would be as a result of a policy gap or vacuum. When asking the NHS Executive's Lead Officer for mental health in Trent Region where the DHAs had policy discretion, he cited the following example:

> Yes. A good example of this is the siting of acute psychiatric units. It was assumed that these should be on DGH acute sites, but over the years there has been a shift away from this assumption – no sudden change but the policy withered. DHAs weren't sure what the national policy was, now we know that there *is* no policy on specific location. If there is a policy at a national level it has to be followed. If there is not a specific policy, that is where the discretion lies – in the gaps.
>
> RHA1.interview, 11th August 1997)

This example demonstrates how policy initiation and policy formulation can overlap. There is no evidence that there was a separate process of policy initiation before policy formulation. There is significant evidence that the policy formulated in that region was not on the agenda for discussion at the Macro level at all. We could even argue that the policy only emerged as it was implemented. If we consider how this compares to the Venn diagrams in Chapter Three, this is one of the few early examples where the Micro level was operating in a normative model, because it initiated, formulated and implemented policy, all at the same time. We shall return to this point in Chapter 7.

Overall, we can conclude that policy has the potential to get initiated at the Meso level, either in collaboration with the Macro level, or where there is a policy vacuum. We will now consider how this process of policy initiation occurs at the Meso, linking level, first following through the case of *mentally ill people in psychiatric hospitals.* A more minor example of the case of *mentally ill offenders* will then be considered, as it brings us up to date, and enables us to ascertain whether there are in fact any significant historical differences in the way mental health policy has been initiated.

5.3 How do issues turn into problems at the Meso level?

In the example in section 5.1 we considered the issue of mentally ill people in psychiatric hospitals at a Macro level, and reviewed how this was translated into the problem of 'institutionalisation'. We can now consider how this issue was perceived and re-framed as a problem at the Meso *and* Micro level, by examining the circumstances of one of the 'early movers' (DHA1/Prov.1). In the early 1980s, one Meso DHA in collaboration with a Micro provider unit started to initiate policy from the middle downwards. Whilst there was a general debate about the pros and cons of community care as a concept, no district had actually started the process of planned patient discharge and building up of community based services. There was a vague idea therefore of community care and the critique of the hospital as a social institution was well

underway internationally. The concept of community care was more of an ideology ('The adoption of an all encompassing but vague community care ideology by politicians' Ramon, 1996: 24) than a fully formed policy. But there were no directives from the centre to initiate or formulate policies locally to respond to this demand. When asking managers in DHA1/Prov.1 how much choice they had about the move to community care, they did not see it as a central initiative at all; the hospital Chief Executive said 'The first job was to try and improve existing services.' (PROV1.interview, 3rd November 2000). Asking managers about the advice they received from the centre, his response was as follows: They (the Region) said: 'Don't put your head above the parapet, lads.' '

However, five years later, this provider unit was one of the first hospitals in the country to close. The unit then provided community based services instead. A policy had been initiated, formulated and implemented in this very short time span, seemingly independent of any outside influence. Clearly then, the process of policy initiation at the Meso/ Micro level in this provider unit is worth analysis. Using Hogwood and Gunn's framework, (1984:68) we can see how many factors existed that would progress the issue of *mentally ill people in psychiatric hospitals* onto the local policy agenda. The first factor was of *crisis proportions*. There is no evidence that the service was in crisis. It was not subject to any external review at the time, nor was it perceived to be an important problem locally by clinicians, or by the Region. The second factor of *particularity* exemplifying and dramatising a larger issue could be said to be present – in that the problem of institutionalisation had been defined by an international professional community, and was subsequently discussed as an important 'issue' locally too. The *emotive* factor is an interesting one to analyse at the Meso/ Micro level. Although there had been numerous scandals nation-wide, the fact that there had not been an enquiry or a scandal locally in that particular provider unit diluted the effect. The issue was not perceived as *emotive* by the local media, by staff or even by carers. The views of patients in the hospital at that time are less easy to ascertain. Prior to 1983, users had no formal mechanisms for consultation and worse still had no right of appeal

against decisions about their treatment (Allsop, in Beck, Lonsdale, Newman & Patterson, 1992.) The *impact* of the issue was difficult to measure. There was only one provider unit in that DHA however and so the factor of the wider impact on the community did not seem to have a bearing on the issue. The factors of *power and legitimacy* were relevant to this issue of people incarcerated in hospitals. The factor of *fashion* was not particularly powerful. No other provider in the UK had actively addressed the issue and there were no trends that could be observed or followed in this country at least. We can note one overwhelming point from the above analysis. Hardly any of the factors were relevant in this DHA Meso/ Micro setting, yet policy was created and implemented seemingly out of 'thin air'. There must have been other influences at work in this particular DHA.

If we take a more recent Meso example, in DHA3 in 1997 the case of mentally ill offenders was perceived as an 'issue' by the Macro level, but passed down to the Meso level to tackle. Using Hogwood and Gunn's framework again, (1984:68) we can see how many factors existed that would progress the issue of mentally ill people in prisons onto the Meso policy agenda. The first factor is whether the issue has reached crisis proportions. The need to initiate a policy at the Meso level for mentally disordered offenders was triggered by a very small number of dramatic cases that had gone wrong nationally. The media and the public were concerned but at no stage was it possible to identify a single crisis event. The second factor is that the issue achieves particularity, in that it can exemplify and dramatise a larger issue. The larger issues here would be the definition of 'mad' versus 'bad', whether mental illness contributes to crime and the treatment in general of offenders. The third factor is that the issue has an emotive or human-interest angle. Mentally disordered offenders would make this issue very emotive indeed as noted by the lead officer seconded to work up a regional strategy: 'It's a very controversial area of work.' (DHA3.interview, 4th June 1997). The fourth factor is that the issue seems likely to have wide impact. The impact of the issue is particularly difficult to gauge for planners, because of the lack of knowledge about needs in this area as noted by the Meso planning officer:

> Needs assessment will have to look at the number of mentally ill in prisons. National experts cannot even agree how many there are, whether the prisons are full of them or whether we are talking about a tiny number. We are funding a local initiative to assess needs in Nottingham Prison over five years to get good quality information about the range of need.
>
> (DHA3.interview, 4th June 1997)

The fifth factor is that the issue raises questions about *power* and *legitimacy.* The way that mentally disordered offenders are treated will raise such questions – are they mad or bad? – Does their illness drive them to crime, or do they happen to be criminals who are also mentally ill? What is the relationship between the two factors? How should society treat them? If they cannot be cured, what should society do with them?

The sixth factor is whether the issue has become *fashionable* in some way. There was no evidence that this issue was 'fashionable' at a national or even international level.

The above analysis suggests that mentally ill offenders are likely to be fairly low on Meso agendas for policy initiation, but a number of the factors are still unknown. The fact that the issue became a problem, and there was an 'imperative to act' (demonstrated by the needs assessment working party mentioned above) suggests that factors cited above do not tell the whole story. The factors by themselves do not appear to guarantee politicisation and access to the policy agenda but the role of the agenda setters *is* important, as we shall see in section 5.6.

Having considered two examples of issues becoming problems at the Meso level, the policy initiation stage is now considered at the Micro level of policy making. Is policy ever initiated at this level without the close involvement of the Meso level, and if so, in what circumstances?

5.4 Does policy initiation occur at the Micro level?

We have already noted that policy initiation occurs at the Meso and Macro levels, and that the 'early mover' provider unit (PROV1) worked very closely with the Meso level in our main example of policy initiation in the early 1980s. (This was when the issue of mentally ill people in hospitals became identified as the problem of *institutionalisation.*) Although there was significant evidence of the Micro level initiating policy then, how involved has the Micro level been in the policy initiation process in recent years? There is clearly potential for policies to change and become quite different from what governments intended, with quite different outcomes (the 'borders of chaos' model in Chapter Three). But this process could also be related to the policy formulation stage, which we will examine in Chapter Six. The initiation of **new** policy ideas and the whole process of agenda setting does occasionally appear to take place – with a key difference. Most policy initiated at a local level in the late 1990s appears to have a much *narrower* impact than this process at a Macro level. The effect is local rather than national and the policies initiated tend to be small scale, as noted by the planning officer for one DHA: 'This has changed a lot . .. providers should focus on doing.' (DHA4.interview, 26th June 1998).

Identifying how policy is initiated at the Micro level is challenging because many of the day to day mechanisms which actors use in their jobs can have an effect on policy. For example, the choices professionals make about diagnosis and treatment, who to treat, where to refer, how to arrange provision can all have a significant impact on wider policy debate. The interesting point about this process is that it is almost invisible. When questioning professionals about the choices they have in shaping the policy debate, without exception they all consider that they are powerless. (Provider3.workshop.6th August 1988/ Provider4 workshop.18th September 2000/ Prov4.workshop.June 1999) However, it is possible to argue that the Micro level policy that is initiated can have a cumulative effect that spread far beyond the boundaries of a DHA. A planning officer for DHA2 (the 'later mover') cited the example of the need

for a deliberate self harm team (DSH), which was actually initiated by the District General Hospital Accident and Emergency Team: 'DSH was invented in liaison with psychiatry – they got on with it. The Acute Trust (DGH) raised it through their service agreements, Prov2 response was that it was not a problem for them, they would provide the service as long as they got paid ' (DHA2.interview, 30th June 2001). This example demonstrates that other parts of the NHS as well as other agencies get involved in mental health policy initiation, as a by-product of their own service needs. When the Chief Executive of this particular mental health unit was asked about how much choice he had in policy making in general he responded: 'Not a lot. Lots of policies are forced upon us. When I arrived in the early 1980s it was all hospital based care. 1000 beds at P hospital and 500 at K hospital. I was appointed to integrate the two hospitals together and to develop community care.' (PROV2. Interview, 3rd July,2001). So, from the date of his arrival in the post, he was required to follow through an overt policy.

It is important to consider at this stage just how significantly individuals can make a difference in policy making generally and policy initiating in particular. Because individuals get involved in policy making, (and are appointed on the understanding that they can put policy into action) we need to consider the important influence and activity generated by agenda setters. The following sections consider different perspectives on power and influence in this context of agenda setting at the Macro, Meso and Micro levels.

5.5 Agenda setters operating at different levels of power – Macro level

If we wish to consider the actors controlling and influencing the Macro policy agenda, it is possible to view this process of control as occurring at three different levels. At a surface level, it is possible to see a pluralist model of power at work. There is public agreement that 'something must be done', experts and specialists are consulted, the media have their say, consumer pressure groups form, and government is seen to be as a neutral observer or reactor to this process. But this does not show a true picture of Macro events

in the early 1960s. In the field of mental illness, the experts consulted were clinical staff who had undergone training and early socialisation similar to their colleagues and who might have themselves been the focus of earlier inquiries; no doctors' hands could be said to be clean in this respect. The role of the pressure groups at the time was muted and the government may have had vested interests in retaining the *status quo*. (Klein, 1989). This agenda setting process seemed to be more about concealed priorities and conflicts than an open battleground with the government as referee.

If, as we suspect, there is a deeper level on which we might view power operating, three key pieces of work are worth attention: those by Schattschneider (1960), Cobb and Elder (1972) and Bachrach and Baratz (1963). The former writer asserts that the whole process of politics is about establishing priorities, so public policy is necessarily an activity, which manages and contains conflict as a result of issues that are included or excluded. Thus 'he who determines what politics is about runs the country, because the definition of alternatives is the choice of conflicts.' At this level, we would expect government to play a much more active role in the setting of the agenda. Thus the selection of experts and professionals to make suggestions, the membership of inquiry committees and the handling of the public and the media will all be on a basis of damage limitation as the government is ultimately responsible for the failure of a public service. Complementing this process of conflict management and containment by government is the process of blame avoidance by providers of the service. It is in both parties' interests to minimise conflict, and to shift the blame. The most likely focus for blame will not be individuals but will be structures, institutions and policies. It is possible to infer that this process of blame avoidance and conflict reduction resulted in government and provider collusion and sums up very well the stagnant period during the 1950s and 60s, before Crossman's imperative to act.

Cobb and Elder developed this debate in the 1970s, focusing on the way in which conflict is expanded or contained through the combination of perceived

grievances and triggering devices which transform the 'issue' into an agenda item. But their concept was of an agenda that was divided up into two stages: a systemic agenda which is where there is a political consensus on an issue meriting attention, and a subsequent institutional agenda where an issue is explicitly up for active and serious attention by decision makers. It is considered unlikely that an issue will reach the institutional agenda without first finding a space on the systemic agenda. Progress from the more general policy agenda to the specific agenda of decision-makers will entail a process of agenda building. This process expands the issue and brings it to the attention of interested public figures and finally the general public. Cobb and Elder argue that certain characteristics of such issues will make them more or less likely to progress along this continuum. If we consider the key mental health problem of *institutionalisation* in the light of these characteristics, (Parsons, 1995: 128-129) we can conclude that this should become a public 'problem' and hence reach the agenda of key decision makers quite rapidly: the *ambiguous* nature of mental health itself, the *social significance* and *long term* nature of poor mental health, the relatively *non technical* or unscientific nature of mental health illness and treatments available and the lack of *precedent* governing community care options, all suggest that issue expansion should happen very quickly. However, it did not. The nineteen years that elapsed between the perception in 1950 that UK asylums were in a dreadful state and the imperative to act in 1969, is still not explained.

Finally according to Cobb and Elder, the access of an issue into the formal institutional decision making process will 'depend on the extent to which conflict is made visible to the various publics.' (Parsons, 1995:129). The wider the audience, the more likely that the issue will get onto the public agenda. This links back to Hogwood and Gunn's factors of *particularity, impact and human interest* but suggests that these factors, rather than just occurring, could be manufactured or assisted by key agenda setters. Historically, there is evidence that those who had a 'dominant' position in the policy field of mental health, at a Macro level, were motivated to ensure that the issues were contained and restricted. Crossman's decision to exploit

scandal in 1969 was made despite the 'reluctance of some of his civil servants' (Klein, 1989:80).

If the government is seen as a neutral observer or referee in the first, pluralist model of power, at the second more anti-pluralist level of power, government could be argued to be more involved in the process of agenda building. As these models on conflict suggest a key factor to consider is that of participation in the policy process. Newer pressure groups such as MIND used specific strategies to expand the issues: engaging in socialising and politicising the issues (Hunter, 1992). But how were they empowered and why had their time come, in 1969? An illuminating comment on how pressure groups achieved this comes from Klein who writes that: 'The challenge for Ministers was how to create a political coalition for change ... hence the decision to exploit the hospital scandals, hence the decision to subsidise MIND' (Klein, 1989:81). This observation suggests that the government made a deliberate decision to make a drama out of a crisis: to ensure that they would gain the 'imperative to act.' This was the end then of policy initiation and the beginning of policy formulation. Change was engineered at a Macro level, through exploitation of many of the factors, which were occurring at that time. The factors in themselves did not trigger change; the way they were used by the government, (no longer a neutral referee) was what generated the imperative to act. The decision by the government to act cannot be explained by reference to power models, but it can be explained if we look at the role of ideas and ideology. This point is taken up later in Section Nine of this chapter. But we still need to clarify how the government used these factors, whom they included in their inquiries and whom they left out. We need to assess who lost and who gained as a result of this new chapter in mental health policy – the end of the stagnant period of the 1950s and 60s and the imperative to act from 1969.

Bachrach & Baratz were also interested in who gets left out and in which circumstances. They argued that non-decision making involved the containment of decision making so as to keep attention on 'safe issues by

manipulating the dominant community values, myths and political institutions and procedures' (1963). They used language such as 'suffocate', 'kill' 'maim' and 'destroy' and suggested that this process of suppression and non decision making went right through the policy process, including activity (if all else failed) at the decision-implementing stage. This view on power seems to be predicated on an assumption that key actors have influence throughout the structuring of the policy process. This means that key actors would need a very long arm indeed to control devolved public services. At a superficial level, the multi-agency nature of mental health services, the very independent nature of the professionals and the distance (geographically and hierarchically) of the centre from the periphery suggests that this process is unlikely to occur in mental health services. Klein (1989:80) notes: 'The case of the services for the mentally ill ... demonstrates the limited ability of the centre to shape the pattern of services at the centre.' But if we consider the position for chief executives at the Micro level since the new Labour Government came to power in 1997, their comments tell a different story: 'I am two telephone calls away from the Minister' stated one chief executive. (PROV2.interview, 3rd July, 2001). There is also evidence that non-decision making still takes place at the Macro level as noted by the planner in DHA2 in the following discussion, in 2001, of the problems associated with the abolition of ring-fenced resources for mental health. When the Meso level requests new resources to fund new mental health projects the response is 'invariably: "It's in your base allocation".' (In other words, you have to fund these developments from the general NHS pot.)

If we look at the wider concept of *participation* more recently, we have already noted the medical profession's dominant position in the policy field of mental health, at a Macro level. This group was motivated to ensure that the issues were contained and restricted. However, newer pressure groups used specific strategies to expand the issues: engaging in socialising and politicising the issues. One such pressure group (MACA) according to their Parliamentary Officer, is involved at a national level in 'providing services as well as raising awareness of mental health issues with ministers, MPs, Peers and other

opinion-formers such as church leaders,' (Int.maca.4.8.97). The Association is quite proactive, and sees its role also to 'Target professional staff and civil servants in government departments (especially the Department of Health), often informally over lunch, who can then shape and inform ministers views'.

(MACA.interview, 4th August 1997)

This transcript highlights the strong lobbying role of such pressure groups, who consider that they have a strong representative role (1200 users and carers in this case). But it also tells us about the mechanisms by which pressure groups exert pressure – informally, as well as formally. Pressure groups such as these have noted a difference in relationships between the Shadow Government pre 1997, and the newly elected Labour government in the same year:

> In policy terms, relationships with shadow ministers have changed since the new Labour government. Obviously they are less accessible now, and relations can be arms-length. As roles change, so do relationships, but one to one relationships are still very important, not just within the DoH but with the Home Office, the Environment etc.
>
> (MACA.interview, 4th August 1997)

The respondent considered that individual relationships and interactions at this level were very important, judging by his comments above. He was also very aware of the tensions in the contractual relationships that their organisation held with the statutory authorities: 'About 95% of funding comes from the local authorities and DHAs through the contracting system –it is very much a 'contract culture'. When asked how this affects their campaigning role, he replied: 'MACA's prime function is to provide services, but we also wanted to play our part in influencing government policy – not a campaigning role, but there is an element of information/ influence which is reflected in my role.' Asked how these two aspects fitted together, the reply was 'The Council looks at strategy – the day to day running of the organisation is separate.' The respondent's role included 'analysis of new potential legislation around mental health and community care' and 'creating MACA policy briefing sheets.' The green briefing sheet was sent to over 1,000 prospective parliamentary

candidates in the run up to the 1997 election, and summarises the views held by MACA on current Care in the Community initiatives. This document underlines the successes for the vast majority of people in the community with mental health needs, talks about the rights of these people in terms of access to normal services, and stresses that these people should live as far as possible where they choose, like any other citizens. The briefing paper is a powerful example of how pressure groups are working to counterbalance negative images of the mentally ill in mainstream media. Whether such a pressure group has truly influenced politicians is open to question, but some influence can be inferred if we note the planner's comments in DHA2, in 2001, that mental health policy at a Macro level was 'spot on ... keeping people in their own homes as long as possible.' This policy is fits closely with MACA values and objectives.

The *means* by which dominant actors excluded others from the decision making process were later explored (Bachrach & Baratz, 1963) and included the use of *sanctions, co-option* and *setting up new barriers*. If we consider these means in the context of mental health policy making in the early part of the 1960s, the overwhelming impression is less of active exclusion of pressure groups, and more an 'identification of an alliance of indifference between the medical profession and the lay managers of the NHS' (Klein, 1989: 81.)

Whilst dominant actors simply ignored new players in the process of policy debate in the 1960s, there were also much deeper forces shaping people's views and aspirations about what was possible and feasible in future mental health services. In this context, it would be impossible to conclude this section on power in policy initiation without reviewing Lukes's work (1974). Whilst a visible and articulate pluralist model gives us a 'surface view' of how power is distributed and many anti-pluralist views cover issues such as agenda control, the mobilisation of bias and rule setting, Lukes suggested a third, still deeper view of power. He considered that there was a 'covert' level of power that involved the shaping of beliefs and wants and the manipulation of myths and symbols. So if we use Lukes' analysis, we can see that the agenda setters

at the deepest level are the people who can shape beliefs and wants; who can manipulate myths and symbols. These people may not be exclusively working at this level, but may be working across the whole hierarchy of power. At an intermediate level, they will be containing and restricting the debate, keeping things on or off the agenda. At a superficial level, they may also be involved in a more pluralist 'consultation' process. However there is no doubt that to be effective they have to work at a deeper level first, in order to shape the perceptual world that we live in and to contain and restrict the policy agenda.

It is generally assumed that this 'covert' level of power works in favour of the *status quo*. It is also accepted that governments generally have policy changes demanded of them, rather than initiated by them. The reactive nature of most governments implies that long term policies are 'rarely waiting in the wings' (Ramon, 1996:18). Governments tend to listen to differing views and pick options that require the 'least change from existing policies and structures.' However, examination of the government's role at certain points in time suggests that real change, for instance from the stagnant sixties to the imperative to act in 1969, was driven by deliberate use of covert power at a Macro level. Whether this was because the government saw itself in a policy crisis, or because of the individuals' actions at the time, is not yet clear. What we do see is government ministers signing up to two 'big ideas', which paved the way to the next stage of policy formulation. The first idea was 'The integration of psychiatry into medicine according to the wishes of psychiatrists and nurses and the belief of politicians and the general public in medicine' (Ramon, 1996:14). The perception of mental illness as a disease that could be cured was a key factor. The second idea did not flow from the first but was mediated by experiences in other countries as well as a preoccupation with costs, as noted in Chapter Two. This was the 'adoption of an all encompassing, but vague, community care ideology by *politicians'* (Ramon, 1996: 24). Thus, it was a political rather than a professional or administrative *imperative to act*. The issue of people being locked away in asylums had been re-defined as a medical 'problem' that led to many UK professionals pressing for a hospital 'solution'. However wider economic and cultural imperatives

led to a rather different community based solution. The beliefs and values that emerged at this time became the cornerstone of the government's drive towards improving hospital conditions and ultimately to replace them with care in the community. This was by no stretch of the imagination a 'policy' but as noted above, an 'ideology'. The government was making use of covert power by shaping people's beliefs and values to drive change. What seems to be important at the end of policy initiation and the beginning of policy formulation is the role of beliefs and ideas. Is it possible that ideas and beliefs trigger this imperative to act?

Before considering this theme, we will follow through the policy issue of mentally ill people detained in hospitals to review how agenda setters shaped this issue at the Meso level. This review will be followed by a more recent Meso example of the policy issue of mentally disordered offenders.

5.6 Agenda setters operating at different levels of power (Meso level)

To consider the actors controlling and influencing the policy agenda at the Micro level, we can revisit the three levels of power outlined in the above section. A pluralistic view on power would show different groups freely interacting and exerting power and influence. But at the Meso/Micro level in the 'early mover' case, (PROV1) it is difficult to see how this process would operate. There were no active user groups, carers either did not express a view, or were openly antagonistic to any change: 'Obviously keen on retaining a space that lets them off the hook both ideologically and practically', observes Ramon, somewhat controversially (1996:28). Professionals were aware of the international critique of institutionalisation but the most of the medical staff in particular were not interested in change, according to the local manager: 'We had one good psychiatrist.' (Prov1.interview, 3rd November 2000). The use of the term 'good' gives a clue as to how the policy debate was conducted. This point will be revisited under our discussion on language and rhetoric. The media were not involved in the policy debate locally, because of the lack of local 'scandals.' There was little support for change

from the centre: 'They (Region) hadn't a bl** clue.' (Prov1.interview, 3rd November, 2000). So, we need to ask, who managed and structured this policy agenda, who established priorities for policy debate and who defined the alternatives?

Where there had been scandals, the selection of experts and professionals to make suggestions, the membership of inquiry committees and the handling of the public and the media had been on a basis of damage limitation as the government is ultimately responsible for the failure of a public service. Complementing this process of conflict management and containment by government was the process of blame avoidance by providers of the service. It was in both parties' interests to minimise conflict, and to shift the blame. The most likely area to attract blame would not be individuals but structures, institutions and policies. It is possible to infer that this process of blame avoidance and conflict reduction resulted in government and public service provider collusion in the affected districts.

But back in 1980, at a Meso level where there was no real scandal, no agenda for change from above and no real professional and clinical pressure for policy initiation, a policy issue translated into a policy 'problem' from what appeared to be a complete vacuum: 'We soon realised we'd spend our whole b** lives doing this (trying to improve existing services) and decided to cut our losses.' (Prov1.interview, 3rd November 2000). Is it possible that this major shift in policy direction occurred as a result of a few influential colleagues deciding to cut their losses? If so, how did they manage to get this issue onto the more political policy agenda?

Cobb & Elder's work (1970) on how issues progress from a systemic agenda to an institutional agenda through the process of agenda building can be examined in the Micro context. The factors of *ambiguity*, the *long term nature* of mental illness and the *lack of precedent* governing community care options suggest that issue expansion might occur. Traditionally the medical profession was viewed as 'dominant' in the policy field of mental health at the

Micro level, although nowhere near as dominant as other medical branches, as noted in Chapter Two. Although this group had ensured that issues were contained and restricted, internationally newer groups used specific strategies to expand the issues – engaging in socialising and politicising the issues. These groups included the new and emerging professionals in the 1970s such as nurses, psychologists, and social workers (the frontline of the international *critique of the hospital as a social institution*). Managers were also a new 'challenging' group, post 1983 and the Griffiths advent of general management. They were expected to lead hospital teams rather than to support the medical departments, and consensus management was abolished. Managers were paid more, had more expected of them and even started to take control of medical staff contracts and appointment procedures. But the advent of general management post-dated the emergence of the 'early movers' in PROV1. And so the leap in policy that occurred in one unit is still unexplained.

Bachrach & Baratz (1963) were primarily interested in suppression and non-decision making, and this describes very well the activities that predated the 'early mover' unit's policy change. It is tempting to view the later agenda setters in this unit as in a different category from the early dominant medical group. However, if we consider the *means* by which dominant actors excluded others from the decision making process such as the use of sanctions, co-option and setting up new barriers, we can see that the new players were still playing by the old rules. If we consider sanctions first we can note that administrators had significant powers in the 'early mover' unit (Prov1). When questioned about how much discretion he had in shaping policy, the Chief Executive replied: 'Discretion? Complete and absolute'. They utilised the recruitment process, joint finance arrangements, and the 'lack of clarity and support from region and nationally' to drive changes and to exclude non-players from their planning processes. When we consider the weapon of co-option, it is evident that the 'early movers' were very careful to include an emerging pressure group from the beginning of the process: 'We negotiated the very important guarantee of no compulsory redundancies, which kept the

Trades Unions 'on side' '. They had just lost their geographical links with the County Council, and so there were difficulties in involving social services in those early years: 'In hindsight I would have put more effort in here' stated the chief executive. But overall, a picture emerges of a very tightly knit, hospital based group at the provider level, supported by the Meso level, by what seems to be an unusual if not unprecedented degree: 'The main advantage we had was at the DHA level in the DA (District Administrator). He supported the whole process 100%. ... his role was vital.' (PROV1.interview, 3rd November 2000). Discussing this key role with other managers in that Region they commented that the DA: 'put his reputation on the line', he 'took the whole issue very personally', he 'made it his own personal crusade.' (IHSM.Conference interviews.June 1990). This support was in contrast to other chief executives' experience, as noted in the later mover (PROV2). When questioned about the bidding process to Region for capital monies the chief executive in this unit replied: 'I'm absolutely certain that the DHA were lousy advocates.' In general he believed that the unit was battling alone: 'Any progress was in spite of rather than because of the DHA. They seemed impotent.' By the time the internal market was set up in the mid 1990s, relationships had deteriorated still further: 'Then with contracting and Trust status we had open war.' (PROV2. Interview, 3rd July, 2001). Matters did not improve until the Department of Health issued an 'edict' requiring DHAs to work in 'partnership' with provider units and Trusts (Department of Health (1997a.).

I have noted that in the 'early mover' unit the new players were playing by some rather old rules, and this can be seen in they way that they (perhaps inadvertently) set up new barriers. Informal planning in DHA/PROV.1 often occurred in the evenings and much policy discussion would happen late at night in a pub, or in people's homes. Participants included staff from the Meso and the Micro level. However, although members were co-opted through informal networking, they were still drawn from the existing hospital services, rather than from the community itself and only included staff who were committed to the concept of community care. (Personal archives/ 1983.)

But whilst dominant actors used a variety of methods to exclude other players from the process of policy debate, what is significant about the above analysis is that these dominant actors had until recently been 'new players.' The 'new players' in both units were playing the same power games as their predecessors. A mystery that still needs clearing up is how and when these 'new players' achieved this revolution. This process was not incremental – the 'old guard' had been in force for over forty years, in both the DHA and the unit and yet in the space of three years, the 'new players' were in full control, playing successfully by very similar rules. The community care policy's time had come in the first DHA and hospital (DHA/PROV1). All the issue progression in this unit may have occurred as a result of deeper cultural factors which we will return to at the end of this chapter.

The above events occurred nearly twenty years ago, but if we take a second Meso case which is more recent (1997) in DHA3, it is possible to follow through the issue of *mentally ill offenders* to see how the use of power affected their emergence onto the policy agenda in quite different circumstances. To consider the actors controlling and influencing the policy agenda at the Meso level, we can revisit the three levels of power outlined above. A pluralistic view on power would show different groups freely interacting and exerting power and influence. Anti pluralistic views on power however, where the Meso level of government is more involved in the policy battlefield, seems to be nearer the mark in the case of policy initiation for mentally disordered offenders. The DHA was keen to second a member of their planning team to lead this because of financial pressures, according to the lead planner in DHA3. The planner concerned considered that she was chosen because she was well known and well connected. The providers were keen to see an 'impartial' actor leading the process because of the nature of the rivalry between providers at that time (1997):

> I have been seconded for half my time to work up a regional strategy for this. This was triggered by the dept of health regional outpost financial advisers ... my name kept cropping up. The DHA did not resist because of the downward pressure on management costs. It's a

> very controversial area of work, and rivalling providers with vested interests needed to see someone impartial and neutral / credible leading this initiative.
>
> (DHA3.interview, 4th June 1997)

What we now need to establish is how the issue got from Cobb and Elder's systemic agenda to the institutional agenda where an issue is explicitly up for active and serious attention by decision-makers. Cobb & Elder argue that certain characteristics of such issues will make them more or less likely to progress along this continuum. If we consider the key mental health problem *of 'treatment and rehabilitation of mentally disordered offenders'* in the light of these characteristics we can postulate that this should become a public 'problem' and hence reach the agenda of key decision makers quite rapidly: the *ambiguous* nature of crime and poor mental health itself, the *social significance* and *long term* nature of mentally disordered offenders, the relatively *non technical* or unscientific nature of mental health illness and treatments available and the lack of *precedent* governing security options all suggest that issue expansion should happen very quickly. In this case, the issue of mentally ill people in prisons was perceived to have been exacerbated by the intervening community care initiative. Solving the problem of 'institutionalisation' by care in the community had created a further 'problem' (perceived by the public) of 'mad' people being set free to commit crimes, typified by 'moral panic' from the media. (Cohen, 1980: 9). In fact, issue expansion had indeed happened very quickly, moving from the systemic to the institutional agenda, largely because of the above factors, but helped along by the possibility that it was a 'spin off problem' from the Care in the Community initiative. In Chapter Three in *Old Sins Cast Long Shadows*, the relationship between problems, solutions and the resultant spin off problems was discussed. As soon as actors formulate a policy to solve a problem, further problems will emerge as a result of the new policy that will then need new policy action. Spin off problems will be deemed politically sensitive by the nature of the (arguable) direct link with the original policy and of course the policy makers.

Finally according to Cobb and Elder, the access of an issue into the formal institutional decision making process will 'depend on the extent to which conflict is made visible to the various publics.' (Parsons, 1995:129). The wider the audience, the more likely that the issue will get onto the public agenda. There is no evidence that planners within the NHS publicised the problems of mentally disordered offenders – they admitted that they knew so little about the size of the problem that they could not begin to formulate a policy to deal with it. The nature of closed institutions, whether prisons or psychiatric hospitals, does not make them amenable to public debate. However, if the professionals were not publicising the issue, the media were making up for this reticence. The most likely explanation for the issue finally becoming a 'problem' based on the above analysis is that the cases that did go wrong nationally were covered to saturation by the media, so 'something had to be done'. The role of the media in mental health issues has been very thoroughly reviewed by Ramon (1996:186-209). The key points that are important in this example of mentally disordered offenders arise from her analysis of the Hungerford massacre of 19 August 1987. The event raised the following issues for the newspapers: the need to give meaning to this act of violence, to attribute responsibility and blame, to demonstrate solidarity with the bereft community and to contemplate the preferred policy solutions. Attribution of blame and policy options will thus be in the public mind, forcing government to act. Government response to such media pressure can be ascertained by consideration of the consultation paper they issued; 'Mentally Disordered Offenders: Sentencing and discharge arrangements', (Department of Health, 1996) which included a discussion on the need for new powers (Author's highlights):

> The Government recognises the valuable contribution which hospital orders and restriction orders have made in *protecting* the public, and expects these orders to continue to perform a central function in responding to serious offending by people suffering from a mental disorder. There are, however, cases in which the powers currently available to the courts appear to be *insufficiently flexible* to meet the needs of sentencing. These are specifically cases where the court is satisfied that

there is a need for the defendant to receive treatment in hospital for the time being, but

- it is not certain that such treatment will not sufficiently *address the risk to the public* posed by the defendant, or
- a *punitive element* in the disposal is required in order to reflect the offender's whole or partial responsibility.

It is to the needs of these circumstances that the proposed new powers would be directed

(RMHLG/5 issued on 3rd May 1996)

We can deduce a number of important points from the above text. The first is that the Government's overt concern lay in *protecting the public*. The second point is that the Government did not wish to imply that the current system was a failure (hence the use of the phrase *insufficiently flexible*). The third point is that the Government wished to be seen to be tough on crime and its perpetrators (by the reference to *punitive*). An important point to conclude with is the distribution of this consultation paper. It was sent to the NHS and Social Services, Probation and Police Services, the Law Society, Magistrates' Association and other legal agencies, as well as all the professional organisations such as the BMA, IHSM, RCP, RCN, and RCGP but the list did not stop there. No fewer than fourteen mental health pressure groups received this consultation paper, demonstrating the Government's concern with public opinion in this difficult area of mental health policy initiation.

The above issue of mentally ill offenders is just one example of an anti-pluralist model of policy initiation working at the Meso level. If we look more generally at the whole concept of *participation* it is possible to demonstrate that the interests of certain groups who had a 'dominant' position in the policy field of mental health, at a Meso level, were motivated to ensure that the issues were contained and restricted. Newer pressure groups used specific strategies to expand the issues – engaging in socialising and politicising the issues. Fieldwork shows that the Meso level in 1997 was quite active in this respect although definitions had to be clarified. The following comment from the DHA3 planner demonstrates that providers were now considered to be a

'pressure group: 'There is formal commitment at the highest level to work in co-operation with providers.' (DHA3.interview, 4th June 1997). It is interesting to note that mental health service providers were now considered to be a 'pressure group' by the Meso level. Clearly the purchaser/ provider split had changed relationships in many ways. When the DHA3 planner was asked about interactions between the DHA and external pressure groups, the response was quite mixed: 'User contributions vary from expressing views and preferences through to setting their own agendas (eg suicide rates). They may act like a pressure group or simply another pair of hands to facilitate our agenda.' The local provider chief executive stated: 'There's a very strong and active user movement. The city wide patients' council, a carers group, an advisory group...' (Prov3.interview.19th August 1999). Discussion with the officer for the local branch of MIND painted a somewhat different picture:

> The statutory services tend to dictate the type of service they require, and it is difficult for us to be proactive with the low resources that we have. But we do have commissioning meetings with Social Services/ Health where we can negotiate changes in unit costs and shape issues such as care management assessment.
>
> (MIND. interview, 13th August 1997)

The dilemma for the local branch of MIND was that they were also involved in provision of services, and so the relationship with the DHA was contractual:

> Locally our role is that of service provider working in partnership with statutory services through the process of contracting and service level agreements with health and social services. Eighty percent of the Social Fund has to be allocated to voluntary/ private sector provision and so it is a little like a shotgun marriage! The fact that the statutory sector fund most of MIND's work locally makes us behave more politically. You have to be terribly diplomatic and try to collaborate and avoid unnecessary conflict.
>
> (MIND. interview, 13th August 1997)

The above evidence all points to the potential use of subtle methods for excluding people from decision-making processes, through the use of contracts and regulatory procedures. Bachrach & Baratz (1963) argued that

non-decision making involved the containment of decision making so as to keep attention on 'safe issues by manipulating the ... political institutions and procedures'. Whilst active and independent pressure groups at the Meso level could challenge this process of non decision making, the use of sanctions, co-options and barriers were all deployed. The most powerful sanction was the ability to withdraw or not renew contracts for services. Co-option was variable: the use of local planning groups in DHA2 tended to be drawn from a relatively small pool of experts who had worked together in the past and who were 'one of us'. (personal archives, 1988). Service users were ostensibly welcomed at the DHA3 Meso level according to their planner: 'In 1992 we set up a purchasing for users group, and there is a service user representative at a number of our planning groups.' (DHA3.interview, 4th June 1997). But digging below the surface, we discover that this was not necessarily the norm. Questions regarding the exact membership of these groups yielded the following response: 'Practice is still rather shaky though. It depends who convenes the group. For instance a medic might convene a totally user less group as they would use a different network.' By 1997 some of the barriers had been successfully broken down: 'We do fund posts such as advocacy/ patient support workers who are independent.' The DHA had made a real attempt to support and empower users in the consultation process, but it is clear that there were still many gaps. There were also many problems identified with user needs and representation: 'The above problems pale into insignificance compared to the key problem; that there are at least five thousand different user views on any subject.' (DHA3.interview, 4th June 1997).

There were some other barriers that prevented users and pressure groups from getting involved in the policy initiation process. Some of these were practical – the times and venues of meetings, the structure of agendas and the formal running of meetings did not lead to user friendly consultation processes. (personal archives, 1988).

Overall, whilst the process of participation had become more open and transparent over the last ten years, it was far from consistent. As might be expected, there were much deeper forces shaping actors views and aspirations about what was possible and feasible in future mental health services at a Meso level. In this context it is essential to conclude this section on power in policy initiation by returning to Lukes's work (1974). Lukes's third, covert level of power: the shaping of beliefs, wants and the manipulation of myths and symbols is difficult to test through the use of structured interviews. However, listening to a narration on behaviour in meetings and paying attention to the language of professionals and managers yielded important clues. In DHA2, (the later mover) the Meso level was actively involved in shaping beliefs and values, as can be demonstrated when we examine the discussion with a provider turned purchaser, with a clinical background. When asked if the DHA attempted to shape beliefs and values, she said:

> Yes. People leading policy areas tend to believe in this policy. There was a turbulent time in the mid 1990s re the closure of the second hospital. The commissioning director (non acute) had very strong values and really pushed for closure of K hospital. She used all the external forces possible to challenge existing practice – meetings, information. She got in the Sainsbury Centre and the Independent Review group who were very critical.
>
> (DHA2.Interview, 30th.June 2001)

When I asked her whether she could give an example of how the DHA put their values into practice, she gave a compelling account of the differences in values that existed between the DHA and the Provider unit at the time:

> We've implemented a fairly structured approach to user voice. They (advocates) are trained to interview clients about issues like care programmes; they act as action researchers. The Joint Consultancy Board (Trust, Social Services, Primary Care Groups and the DHA) meets regularly. The user advocates presented their findings and the reaction was ... 'interesting.' The Chief Executive of the Trust pointed out that he was paying for the research and did not want to use the results. Service users found that very difficult. The findings DID go to the Trust Board, and were responded to through an action plan. The

> DHA constantly referred to it, as good practice. We pay service users for their input.
>
> (DHA2.Interview, 30th.June 2001)

The above evidence of a very strong clash of values demonstrates how the tables have been turned in this instance. Clients of a service that had historically been excluded from debates about policy were empowered to express views that were then incorporated into policy. Again, the key role of the Meso level should not be underestimated in this respect. The power struggle demonstrated at that meeting is not covert by any means, but a quite subtle use of cultural pressures and expectations were used by the DHA to shape the debate and the outcomes.

Once again, there is evidence that utilising covert power to change behaviour has been a successful strategy in a number of DHAs.(*fighting fire with fire.*) Whether this is also the case at the Micro level is considered in the following section.

5.7 Agenda setters operating at different levels of power (Micro level)

Having reviewed how the issue of *mentally ill people in hospital* gained access to the policy agenda at the Meso and Micro levels in DHA/PROV1, we can now focus more clearly onto the Micro level to consider how the use of covert power shaped decisions and agendas. In this context, it is essential to include Lukes's work (1974) on covert power. This helps us to unravel the mystery of how new players so comprehensively swept the board at the Micro level in the 1980s and 1990s. Lukes' third, deeper view of power: *the shaping of beliefs and wants and the manipulation of myths and symbols* as we have noted above is difficult to gather data for, through interviews or direct questioning. But working at the Micro level for a number of years yields rich and compelling evidence about this third level of power. Not only did the new players adopt powerful non decision-making tactics suggested by Bachrach and Baratz (1963). In order to get to this stage of policy agenda and control,

they were extremely skilled in shaping beliefs, wants and manipulating symbols and myths to 'set the scene'.

In PROV.1, (the 'early mover'), the appointment of the Hospital Chief Executive in 1982 was a key decision. A high flying product of the NHS Training Scheme, he was expected to work in a large acute hospital before being seconded to the Meso level, and then working his way to the top of the NHS, at regional or even national level but for the first time in the history of the NHS Training Scheme, a trainee was appointed to head up a Mental Health Unit and directed by the District Administrator to 'make a difference'. Suddenly, young managers' perceptions about career planning changed almost overnight. The new incumbent recruited a new team drawn from a multi disciplinary background, who were all expected to be totally committed to changing the way mental health services worked. They were warned that it would be difficult and that there would be many barriers ahead; the journey was perceived as unclear and fraught with dangers but the rewards would be high: a chance to re-shape a service, to be first in a new policy direction, above all to release patients from the tyranny of their bleak surroundings and to help to plan better futures for them. The message, the beliefs were almost revolutionary, and best of all, the possibilities for real power without having to defer to doctors were in their grasp.

Moving forward five years and looking at another provider unit we can see that local planning groups in the late 1980s were still notable for their lack of user representation but by then they were also notable for their lack of hospital staff membership. In DHA2 (the 'later mover') examination of the mental health planning network (personal archives, 1990) reveals that senior members of a mental health unit were leading a 'steering group' which was supported by locality planning groups comprising community health and social services staff. But hospital 'shadow' groups based on patient classification rather than locality (demanded by the medical staff) had no linking membership with the steering group or local planning groups, and were effectively marginalised. Membership of the steering group was organised around the chair's peers and

supporters, who were known as the 'blue eyed boys / girls.' Limited community services had already been set up and there were significant new tensions between the 'new ' community staff, and the 'old' hospital staff that constituted another barrier.

In the provider unit 2, in 1987, we can see how the process for drawing up a key document also shaped beliefs, and manipulated symbols and myths to 'set the policy initiation scene.' A document entitled *Principles of a Community-based Service* was written and imposed on staff and users locally. It was a set of principles drawn from a much wider culture of the new community ethos and the writer was the top grade psychologist for mental health in that unit. The focus was on a very broad conception of mental health, the emphasis was on collaborative working between health, social services and the voluntary sector, the service would value and involve the client and seek to integrate users into natural community networks. The philosophy was considered fairly revolutionary by the hospital staff, and the principles were used as a yardstick to measure ideas for subsequent policies. It also became almost a sort of catechism. Staff were expected to learn, understand and above all believe in these 'principles' if they wanted to be in the 'front-line' initiating and planning the new services. (Personal archives, 1987). Another example of culture shaping lay in the 'new players' background and training; the main protagonist in PROV2 trained in psychotherapy before he went into management key supporters were the top grade psychologist, occupational therapists, ex-social workers and nurses, most of whom were placed in management positions. The combination of psychological and management skills appeared to make them invincible. Interestingly, when the 'key players' moved on, the policy slowed down. Was this because of a natural life cycle, where policy needed to mature and 'bed down' or does this contradict our assumption that covert power was the main weapon utilised? What is certain is that the key players were very skilled in the use of covert power and when they left, it became clear that other staff were less skilled or less comfortable with this approach. This suggests that covert power needs to be utilised by individuals, it is not just a structural mechanism.

More recently, in the Provider 4 unit, which was some distance from the Regional outpost, the Chief Executive commented that his patch was 'on the edge of the empire.' This was seen as a disadvantage, as he believed there was a correlation between the distance from the Region and the lack of support or identity: the focus is 'always on the inner circle'. (PROV4.interview, 17th September, 2001.) If this is the case, the ability of the Macro level to control and shape the more distant parts of the NHS could be compromised.

We have already noted that *participation* in the policy process has had a significant impact on policy changes more recently. At the Micro level, the level and quality of pressure group involvement is varied. It has also changed because of the 1991 purchaser/ provider split. As the Meso level became more involved in setting and monitoring contracts, much of the dialogue and negotiations over quantity and quality of service shifted to that linking level. When a chief executive in Nottingham was asked to list the pressure groups involved in the provision of services, he cited groups that were attending Meso level planning meetings and GP consortia (very much a purchasing role): 'There's a very strong and active user movement. The city-wide patients' council, a carers group, an advisory group.' (PROV3.interview.19th August 1999). So historically, just when user empowerment was taking off in the 1980s and 1990s, structures were put into place that excluded users from the delivery debate at the Micro level and refocused the attention on the Meso linking level.

The above discussion on power demonstrates how important Lukes' third covert level of power has been at the Micro level. The evidence in the 'early mover' unit (Prov.1) as well as subsequent units (such as Prov.2) is that key staff at the Micro level used their professional and managerial as well as interpersonal skills to change the way people perceived mental health services. Old values, cultures and methods of delivering services were all successfully challenged. A key difference between the 'early mover' and the subsequent providers was the support and direction given at the Meso level in the early

1980s. By the 1990s, in Prov.2 the support from the DHA was less evident and there was evidence of significant conflict. The providers had developed their own agendas, drawn from events nation-wide, and did not need the 'change champions' that were so essential to the first 'early mover' providers. The way ahead was clearer, someone else had led the way. They had developed their own ideas about the shape of new community based services, and how they transmitted these to their staff is considered in the next section. We have still not discovered what made the early mover units in PROV1 take those first steps into the unknown. Although power and influence undoubtedly played a part, the role of the 'champion' (the DA) at the supporting Meso level and his relationship with the provider unit needs further attention. How did he share his ideas and enthusiasm for change with the Micro level? The following section also explores this process in more detail.

What seems to be important at the end of policy initiation and the beginning of policy formulation at the Macro, Meso and possibly the Micro level is the role of beliefs and ideas. So far, we have been considering the whole process of policy initiation as a pursuit of interests. But a complementary view of policy making involves the creation and use of knowledge and ideas. This view is a more modern approach, with its roots in a post war era: 'The rise of power based on knowledge in the form of experts or technocrats has been a key feature of post war policy analysis'. (Parsons, 1995:153) It was Keynes who first suggested that ideas shape policy-making: 'I am sure that the power of vested interests is vastly exaggerated, compared with the gradual encroachment of ideas' (in Parsons, 1995: 169). The next section of this chapter looks at this rather different approach to policy-making in more detail.

5.8 Knowledge and ideas in policy initiation at Macro level

There are many approaches to assessing how ideas influence the policy process, but the following three models cover most of the important aspects of ideas and transfer of knowledge in the policy field.

Hall (1989) discusses the power of institutions to absorb and incorporate ideas into the policy process. He considers that ideas are not the only factor in this process. For ideas to be 'adopted' as policy they need a 'good fit' with economic circumstances, they need to be in the interests of dominant political interests and they need to be feasible administratively. Thus this approach tacitly underlines the need for allies and influence. Examination of events leading up to the *imperative to act* in 1969, however, suggests that it was individuals rather than institutions that initiated change, led by the Secretary of State, Crossman and opposed by civil service administrative interests. There is little evidence as to the economic fit (no-one really knew what the implications would be). The political interests alone did not appear to be enough to trigger change under this model. Moving forward twenty-five years, civil servants have similar preoccupations, particularly that of feasibility as noted by the Lead Officer for mental health: 'I am judged partly on how I support ministers... We advise ministers on what can be delivered.' (DoH. Interview 1, 14th March 1996.) Between 1969 and 1996 we can observe a recurring tension between ministers who want to initiate new policy, to 'make a difference' and civil servants who are concerned with economic and administrative feasibility.

As we saw above, Coats and Colander (1989) were interested in how ideas spread and posited three models for this including the infectious disease model. This model assumes that individuals can be popularisers and propragandists of an idea, weakening individuals and groups to make them more receptive to new ideas. The infectious disease model is a fruitful avenue for explaining how ideas might influence the mental health policy process in the UK at the Macro level. It gives credence to the concept of politicians exerting power and influence because of what they believe in rather than because of narrow interests, as exemplified by Crossman's determination in 1969. It also fits with the use made of pressure groups to popularise the issues and push for change. However, when we examine the way civil servants at the Macro level behave in the 1990s, they claim that they had to defend, nurture and support new ideas against politicians: 'One problem is the political

context. This is very strong. The problem of accountability tends to make politicians risk averse, thus we have to defend ideas at an early stage.' (DoH.interview2, 14th March 1996). If these statements are to be taken seriously, what we see here is a shift in roles, from the politicians as the risk taking policy initiators in the 1960s with officers counselling caution, to the officers in the 1990s defending new ideas and politicians demanding the status quo. However if we consider the earlier statement by the 1997 lead mental health officer that 'I am judged partly on how I support ministers... We advise ministers on what can be delivered' there is a significant lack of congruence between the earlier and later statements. How can an officer be defending new ideas, on the one hand and advising ministers what is feasible with the other? Whilst officers' statements may seem conflicting, if we examine *behaviour* the picture becomes somewhat clearer. The following notes taken whilst observing a Macro level officers' meeting at the Department of Health in Leeds, suggest a much more reactive approach to policy initiation. The meeting was called to discuss the Prime Minister's suggestion that the D of H should look into the possibility of creating a single agency to deal with mental health services, instead of the separate arrangements that already existed between health and social services. Members at the meeting included regional mental health officers from across the UK. The meeting started with the following statement from the Chair (lead manager for mental health): 'There's a lot of debate about merging health and LA functions and Number 10 has expressed an interest... It's not supported by the Secretary of State... We need to pick out best practice without going overboard.' (MB/Department of Health meeting, 8th May 1996) This statement suggests from the outset that there was conflict between No 10 and the Secretary of State for Health. It also sets the scene, by the use of the term 'not going overboard'. The message coming through is that not too much time should be invested in what is not seen to be a 'practical idea': 'I would like something to the effect that 'there is no evidence that merger would benefit but we could tinker' sort of outcome... It may well be quite different... but I don't think you'll find a great deal of support ... we need analysis to back up our assertion.' Whilst an attempt is being made to show open

minded-ness (it may well be quite different) the direction has been set, a covert warning was given (but I don't think you'll find a great deal of support) and the chair is overtly discussing how they can construct analysis that will confirm that only incremental change is necessary: ('tinker'). This case is about policy formulation as well as policy initiation. Whilst the discussion is broadly on 'policy options' the earlier aspects of problem definition are also being tackled, as outlined in the Chair's next statement: 'We propose a two day visit to DHAs/LAs. How do we select and how do we present it to the DHA/LAs? What do we say we are doing and what will the output be?' This above case does appear to fit Hall's model (1989) of ideas mediated by other factors, in this case administrative feasibility.

Network and community approaches focus on the way in which policy communities 'advocate ideas in given policy areas.' (Parsons, 1995:173) The concept of a policy *community* in mental health is an interesting one to explore. If we examine the range of actors involved in the mental health policy process at a Macro level, we find that it is a rather 'disjointed aggregate of civil servants, politicians, professional organisations and pressure groups.' (Parsons, interview, 29th March 2000). They all have overlapping interests, but they also have very different agendas. The success of communities in getting their ideas adopted would depend on how persuasive they are and what type of alliances they can build with key decision- makers. This is a fairly 'pluralistic' model, albeit lop-sided (Harrison, Hunter & Pollitt, 1990:15) and as such demonstrates that much of the discourse on ideas and how they affect the policy process is still predicated on power and influence. The success of such communities varies. Social science and mental health groups tend to have less 'certain' knowledge than natural sciences (Haas in Parsons, 1995:174) and these groups tend to lack 'policy brokers' who can inform 'political consumers of knowledge' of the relevance of their findings. The *disjointed* nature of the mental health networks, the *lack of certain knowledge* and lack of *power brokers* in this field suggests that the agenda setting abilities of the mental health community at the Macro level will be negligible. Historically there may have been other reasons for the lack of network or

community pressure. Sir Keith Joseph stated in the early 1970s: 'No-one can see better than doctors the needs of the public and the shortcomings of the service. I am not aware that there has been steady, powerful, informed medical pressure to remedy the real worst shortcomings'. (Joseph, 1973) His charge was of indifference and it was another ten years before ideas gained enough momentum to make real changes in the provision of mental health services.

The most helpful model generally for understanding how ideas spread and gain policy status at the Macro level appears to be that of Hall although the exception to this appears in the 1960s. The determination of Crossman to ignore administrative or economic concerns and the international critique of the *hospital as a social institution* discussed in Chapter 2 fits much more closely with the *infectious disease* model. It is entirely possible to draw the conclusion from these examples, that when there is a real change in policy making, the infectious disease model of ideas is the best fit, and when the status quo reigns, Hall's model fits better. But we need to consider how ideas affect the policy process at the Meso and Micro levels, before coming to any firm conclusions.

5.9 Knowledge and ideas in policy initiation at Meso level

We have already noted at the Macro level that *normally* ideas are unlikely to feed into the policy process unless they fit well with economic circumstances, are in the interests of dominant political interests and are feasible administratively. But there is a real tension between the Macro and the Meso level in this respect. Clearly, the feasibility or otherwise of an idea is very subjective. Meso planners appear to have different views on what is administratively feasible:

> Silly fashions which are often promoted centrally (such as locality commissioning is a good thing) come into play. Nobody knows what we mean by locality and there is no hard evidence to prove that it works. The current buzz phrase is 'project management'. This was

> seen by the chief executive as the answer to everything. Tedious and silly.
>
> (DHA3.interview, 4th June 1997)

So any institutional analysis of ideas and their contribution to policy initiation should be examined in the context of the actors and levels of organisation. Just because an idea is integrated into the decision making process at Macro level does not mean that it will be adopted uncritically at the Meso level. So which ideas do tend to get successfully passed onto the Meso level and why? A documentary analysis of five briefing papers sent from the Macro level to the Meso level (DHA3) in 1996, together with interviews yields some interesting findings. The papers that included published research findings were treated with more attention and respect than briefing papers that did not. Exhortations for DHAs to work through 'project management' or to promote 'locality commissioning' were seen as *'tedious and silly'*. But an occasional paper for example on setting up emergency crisis intervention services was used to shape discussions with planners across the locality and integrated into contractual discussions with the Micro, provider level. This paper had a number of recommendations that drew heavily on appended research findings. The findings were not straightforward, and some contentious issues were discussed by the authors, who were, significantly, expert epidemiological planners:

> The importance of crisis teams has been stressed by us for some time now as one way of reducing the bed demand. Unfortunately this may not always be correct. RP and I have been reviewing the literature. If anything the evidence is that *stand alone* rapid response services create extra work with a new client group, and divert effort away from people with severe mental illness; although largely successful in keeping new clients out of beds, they may not always do this either.
>
> RMHLG working papers: TB 282/ 8th May 1996

Meso planners seemed happy to handle ambiguities, contradictions and complex information; fashionable dictates from the Macro level were received

with less enthusiasm: 'In reality this is all a bit farcical. Top executives have no idea. Experts here spend lots of time giggling.' (DHA3.interview, 4th June 1997)

On the above evidence, the model which fits the Meso planning process best is likely to be the *network* or community approach. The evidence of respected researchers has been included in the discussion paper. The information that they are providing is reasonably '*certain*' knowledge (Haas, 1990:42) as exemplified by the above discussion paper of 8.5.96 and the '*policy broker*' role (Haas, 1990:42) is provided by the epidemiological planners who review the evidence and write the accompanying discussion papers. The fact that the information was provided as a 'discussion' paper rather than as an edict will have helped their case and also points towards a collaborative, networking approach. Finally the admission in the discussion paper that they got it wrong in the past suggests an open-ness that is not prevalent in civil service culture, and again fosters the impression of an open and questioning community.

The final point we need to consider when analysing the contribution of ideas to policy initiation at the Meso level is the historical context. At what points do ideas shape policy? Observing policy actors at the Meso level over a number of years, I think it is fair to conclude that ideas feed into policy throughout this whole process, but in the 1990s, in DHA3, two key points can be identified. The first is when the Macro level issue briefing papers with research findings but there is also an intermediate process, through a powerful team of regional mental health lead officers who meet on a three monthly basis with the NHS Executive. Examination of agenda items over three meetings in 1996 shows a ratio of five to three in favour of 'ideas' for discussion (many led by the regional representatives) as opposed to directive items. However, just because ideas feed into the policy initiation process does not mean that they will be integrated into subsequent policies. This topic is discussed further in Chapter Six in the context of policy formulation.

5.10 Knowledge and ideas in policy initiation at the Micro level

We have already noted that ideas do not follow hierarchical structures. They can come from anywhere, and they can be transmitted in a variety of ways. In the 'early mover' unit, PROV1, the 'infectious disease' model (Coats and Colander, 1989) fits very well. We can identify key people such as the district administrator, the provider chief executive and his team who were popularisers and propragandisers of an idea, weakening individuals and groups to make them less resistant to new ideas. The provider chief executive noted: 'The role of the DA was key in this.. he was the ideas man.' (PROV1.interview, 3rd November 2000). Hall's analysis of institutions and their power to incorporate ideas into the policy process through factors such as the 'economic fit', the interests of dominant political interests and administrative feasibility (Hall, 1989) does not appear to fit *at all* in this context. The hierarchical interests overall were not predisposed to support the new ideas: 'They (Region) Hadn't a b** clue.' The *feasibility* or otherwise of discharging patients from an 800 bed hospital and re-providing services in the community was an unknown. The *economic fit* was not seen as an issue at all. However, five years and another unit later, (PROV2) many of the above factors were seen as important. There was far more attention paid to costs and budgets, administrative procedures for initiating policy such as formal planning groups were set up, and local political interests dictated why one hospital was selected for closure and another was not. (Personal archives, 1987

We can observe from this comparison, that the *infectious disease* model (Coats and Colander, 1989) is more likely to explain events in units that are initiating policy *for the first time._* They are venturing into uncharted territory, so are more likely to spread ideas and shape change through individual activity. The units that are following behind in this process are much more likely to have to pay attention to administrative, economic and political interests as well. (Hall, 1989). The conclusion to this discussion on ideas and their influence is that the 'early movers' had much more freedom to initiate policy and ideas than

the later movers. We have still not established why some units moved more quickly than others, and this is further discussed in Chapter Seven.

Having reviewed how power and interests, as well as ideas affect the policy initiation process, we now need to consider the role professionals play in this context. The following section analyses the role professionals played at the Macro, the (hitherto unexplored) Meso level, and the role of the professional at the Micro level.

5.11 Professionals and power in policy initiation at a Macro level

Professionals in mental health are experts who get involved in social problems. It is easy to assume that professionals only operate at a Micro, delivery level, but in fact professionals have been advising and informing governments about mental health issues throughout the whole of the last century. Professionals exert power through their knowledge and status. These are two very different sources of power and I propose to look at them separately. If we consider how knowledge frames the mental health agenda, we can see that professionals have shaped and defined problems throughout this period. Wilding (1982) argued that health professionals and social workers used five forms of power: through their input into the policy making process, through their ability to define needs and problems, through the allocation of resources, through power over other people and through the power to control their own work. If we examine these forms of power in the context of the Macro level, two of these can be put aside. The power to control their own work is most likely to be exercised at the Micro level, whilst the power to allocate resources (hotly disputed by professionals generally) generally occurs through the use of diagnosis and referral methods, which again are wielded at a Micro level. The use of power over other people can be construed as position power, and generally speaking, professionals are not arranged in a hierarchical fashion. They do not have power over peers or other disciplines. The two most *likely* forms of power that could therefore be utilised at the Macro level are the ability to define needs and problems and

through their input into the policy making process. Professionals have had formal and informal mechanisms for feeding into the policy arena at macro level throughout the whole period covered by this study. They sit on consultative committees, chair inquiries and Royal Commissions, support and advise ministers and civil servants and play a significant role in public life at this level. But the relative powers of professionals in mental health services has been somewhat low compared to professionals in other spheres of health care: 'In terms of the medical profession's ladder of prestige, the specialties in the long stay sector were at the bottom of the hierarchy.' (Klein,1989:80). Professionals have however had significant power to define problems and needs, as we have noted when examining the *critique of the hospital as a social institution* which came from many countries and was led predominantly by social workers and professionals. Their role in informing government and shaping the public's perceptions about the problem of institutional care was vital. Their role in getting the issue of people in institutions onto the public and political agenda was key to this whole process of policy initiation. However, if professionals were instrumental in problem identification, they were much less involved in the consequent care in the community policies that followed: 'Indeed, Britain is a key example of a country with little or no professional push for de-hospitalisation but with politicians adhering to a free market option that has gone much further along the road to de-hospitalisation than in most other European countries.' (Ramon, 1996:28.) On the surface this seems contradictory. How can professionals be pushing for change but resisting the consequent policies? The answer lies in the choice of policy options available to the agenda setters. Care in the community was not a 'natural' response to the problem of institutionalisation. The theme or idea embraced by professionals initially was of mental health services being re provided in an acute (ie general) hospital setting. This tension is further explored in Chapter Six.

There were further problems that lay in wait for the professionals and the way they exerted power at the end of the 1960s. The following two decades showed a development of a critique of professionalism and a 'growing popular

disenchantment with experts and their handiwork' (Parsons, 1995:156.) The final decade of the last century accelerated this process, largely because of financial constraints but there were also concerns coming from professionals themselves. Henshel (1991: 87) explores the risks of entrusting experts with defining and interpreting social problems. Because of their common backgrounds and self-imposed isolation, their ambitions could be questionable, they operate within institutional constraints and tend towards selective blindness. Many writers drawn from professional ranks as well as their critics have had a lot to say about the dangers of leaving problem definition to the experts. Laffin & Young (1990: 35-36) also considered this trend of professional respect to decline in the last Conservative era, with the loss of professionally dominated policy communities and ministers seeking advice from an 'inner circle'. This 'anti-professionalism' has indeed eroded some of the power away from such 'experts' – they have 'found themselves challenged; claims to knowledge are no longer enough for the customer' (Parsons, 1995: 156). This is particularly the case with mental illness services where effectiveness has been difficult to prove, there has been an emergence of competing and non-aligned professionals, experts and pressure groups as well as a new breed of manager running the services and reporting to ministers. Overall we can conclude that professionals throughout this period have had much of their power eroded at a Macro level – 'What was given may be taken away' (Wilding in Parsons, 1995: 158). However they still exert considerable influence at a Micro level as we shall see later in this chapter. The role of professionals in the hitherto unexplored Meso level will also be examined in the next section.

5.12 Professionals and power in policy initiation at the Meso level

In the above section we defined mental health professionals as experts who get involved in social problems. The influence of professionals on the mental health agenda at Meso level can again be tested using Wilding's model (1982). The input to the policy making process and the ability to define needs and problems are the two most evident forms of power that professionals can use

at the Meso level in this respect. The other forms are more relevant to the Micro, provider level. Professionals have been involved in formal methods of consultation and planning since the inception of the NHS, but if we examine their role in the policy initiation process in the 1960s, there was little or no interest in the political drive towards community care. However there was a quantum shift in the role that professionals could play at the Meso level with the advent of the internal market in 1991. For the first time, professionals were actively recruited to management positions at the DHA, and frequently 'poached' from provider units. Their roles were unclear, to begin with – they were expected to negotiate contracts with provider units, and to decide what services were necessary in a given district. The potential was there for rational as opposed to incremental planning and this point is further discussed in Chapter Six. But in the context of professionals and power, this recruitment of professionals into the Meso level had an effect of 'divide and rule.' Meso professionals-turned-planners were expected to challenge conventional approaches from provider units (and who better to carry out this task than the 'poacher turned gamekeeper' professional?) The professionals became technocratic experts, skilled in need assessment and contract regulation, although many professionals at the provider level saw this as an erosion of clinical freedom. Even more recently the creation of NICE (National Institute for Clinical Excellence) in 1999 challenged the role of professionals locally, as noted by a provider chief executive: 'The role of NICE and the Commission (for Health Improvement) is going to make a huge impact on discretion. This new approach challenges professional choices. It's a completely different method of thinking and working.' (PROV3.interview, 19th August 1999.) It is unclear how the Meso level professionals turned planners will relate to the Macro level, in this respect, but there is significant evidence of a service that is being increasingly centralised at the Macro level. In 1997 the DHA3 planner stated: 'The regional review is the mechanism to monitor performance against contract. In reality this is all a bit farcical.. evidence is invented retrospectively, we use euphemisms such as 'in progress'.' (DHA3.interview, 4th June 1997). A year later, in another district, when asking a DHA planner about relationships with the Macro level the response was as follows: 'There is

less face to face contact now, with much less involvement and control; we have a lot of autonomy' (DHA4.interview, 26th June 20th 1998). But by 1999, the chief executive in PROV3 had a very different view: 'All money is targeted, very little discretion there. A big emphasis on delivery including more follow up and monitoring.' (PROV3.interview, 19th August1999). This trend was confirmed by a planner in DHA2 as recently as 2001: 'Now (policy) is SO prescriptive. Down to the number of staff needed in a crisis team. Would have been different in the early 1990s. There was a STEP change with the advent of the Labour Government. Lots of detail, money attached to that...' (DHA2.interview, 30th June 2001)

The above comments across different districts suggest that professionals at the Meso level had significant choice and discretion in policy initiation, provided that they could demonstrate their advice and ideas would improve performance locally. Thus one could argue that they had exchanged their traditional professional roles for a more rational-technocratic approach. But this has all changed in the last two years. The 'step change' identified by the planner in DHA2 is triggering a significant change in policy making. How this affects the Micro level is covered in the next section.

5.13 Professionals and power in policy initiation at the Micro level.

The influence of professionals on the mental health agenda at Micro level can again be measured using Wilding's model (1982). However, we can see two very different pictures if we contrast the early 1980s with the early 1990s. Looking at the policy making process itself, in the early mover unit, (PROV1) the professionals generally had very little power. We have already noted in Chapter 2 that professionals had never 'bought into' the concept of community care in this country compared to their peers in the USA and Italy. At a local level, professionals who were resistant to new ideas were completely marginalised. A minority of professionals who did express enthusiasm for the new ideas were rewarded with more senior posts, co-opted onto planning groups and offered new jobs in the subsequent community services. In the

'early mover' unit, community posts were reserved for key professionals until they had run down hospital services, to stem the flow of quality staff into the community too early. Professional ability to define needs and problems was never more threatened than during this new venture of the early 1980s. Not only were they excluded from new policy debates, but all their previous methods of diagnosis and treatment were denigrated, and consigned to the 'dustbin of history' (personal archives, 1984). Their resistance to the changes was sufficiently strong that the chief executive commented: 'They won't believe this hospital will close until the tractors roll up the drive.' (Personal archives, 1984). The professionals' abilities to allocate resources was also low during this time, as all budgeting systems were held centrally. The power over other people was eroded, as administrators and the Meso level grew in confidence, and the power to control their own work was also threatened, as the whole pattern of services that they had controlled started to literally disappear.

By the late 1980s, in PROV2, the picture had completely changed. New professionals were emerging from the training schools and universities, with very different views on users, institutions and mental health itself. A whole cadre of professionals had taken full advantage of the Griffiths reforms to the NHS, and the advent of general management. In PROV2, professionals had taken over many general management positions, and the combination of clinical and managerial skills gave them significant new powers and enabled them to capitalise on their old skills as well. They 'ran rings round the administrative managers' and 'took full advantage of their unique blend of psychological training and skills to get their own way, when it came to ideas for new services.' (Personal archives, 1987)

By the early 1990s and the advent of the internal market, the providers' power seemed to have grown further according to the PROV2 chief executive:

> Some people say that the DHA grew in power with the purchaser provider split. But knowledge was power. We used to go into contract negotiations and we won most of the time. It took them a very long

> time to catch up, there was very little discussion. There were exceptions, such as NB (ex PROV2 staff) who could muster clinical arguments.
>
> (PROV2.interview, 3rd July 2001)

This is confirmed by the Meso perspective, as a DHA2 planner noted: 'In practice it never felt that the NHS Trusts were subservient to the DHAs. They always held the real cards. Whenever they went to arbitration about issues the Region ruled in favour of the Trusts.' Meso planners were painfully aware of their relative lack of knowledge in the early years of contracting, as she continued: 'The very first year of contracting, the Director of Planning said that if we just managed to maintain the service we'd be doing ok. On the strategic front it was completely divorced from contracting process. This dogged us for years and years. How to link policy strategy to the annual contracts.' (DHA2.Interview, 30th June 2001)

And so we can see that the use of ideas and the ways that these are transmitted are bound by factors such as timing and whether the journey ahead is known or unknown. The role of professionals has undergone a sea change during this period, and their capacity to shape change and exert power grew in proportion to their managerial status. However, the step change identified at the Meso level in DHA2 in the last two years was working its way down the hierarchy. When discussing the relative freedoms that managers had in the 1980s to shape policy, the chief executive of PROV2 stated that he was:

> Left to my own devices. They weren't interested in how we implemented unless there was a complaint. Completely autonomous. But by 1998 you could hardly move without the Region breathing down your neck. We had performance mgt from the RHA and monthly visits – interesting – in fact they were much more autocratic and directive than the old DHA. But national politics were beginning to be so performance led. I was two telephone calls away from ministers.
>
> (PROV2.interview, 3rd July2001)

All the above evidence suggests a pendulum effect, whereby professionals who traditionally held power through their knowledge and status had this

eroded in the early 1980s, unless they 'jumped ship' and moved into management. By the early 1990s professionals had a new opportunity to work at the Meso level, with the creation of the internal NHS market. Here they could increase their power and influence through the contracting process. This however proved to be a mirage. With most of the knowledge and information on client activity initially held at the Micro level, and with the Macro level ruling in favour of the Micro level on appeals, by the time the Meso level developed its skills and knowledge it was too late. A new Government with significantly more control over the 'detail' of mental health policy, coupled with the decision to abolish most of the DHAs by 2002 put an end to this interesting Meso technocratic-professional experiment.

We have examined four aspects of policy initiation: we have considered how original 'issues' might be re-conceived as 'problems' with the influence and activity led by agenda setters. We have then considered three different levels at which these agenda setters could exert power and influence. We have then examined how power can be shaped by knowledge and ideas in the process of policy initiation. Subsequently, we examined the role of professionals and power at the Macro, Meso and Micro level. In the final sections to this chapter we return to the key role of the agenda setters (*not that we ever really left them*). We will examine how they might operate at the covert, deep level of power and influence in the policy initiation process and take a closer look at their ability to shape people's beliefs and desires through the manipulation of language.

5.14 Symbols and myths: language and policy.

In this section we return to the aspect of covert power discussed previously:

> Is it not the most supreme and insidious exercise of power to prevent people, to whatever degree, from having grievances by shaping their perceptions, cognitions and preferences in such a way that they accept their role in the existing order of things, either because they can see or imagine no alternative to it, or because they see it as natural and

> unchangeable or because they value it as divinely ordained or beneficial? To assume that the absence of grievance equals genuine consensus is simply to rule out the possibility of false or manipulated consensus by definitional fiat.
>
> (Lukes, 1974:24)

We have already looked at a number of examples of the use of covert power, at all levels of the organisation and the penultimate section to this chapter looks specifically at how language can shape people's 'perceptions, cognitions and preferences'. The use of language in mental health is one of the few areas that do not fit neatly into Macro, Meso and Micro levels. We can look for evidence of labelling and how words are used in documentation, but to track where they came from and who shaped them is less easy. The following section therefore looks generally at the use of language in mental health services, and only occasionally at the level in which they occur. We can conclude from this that the use of language does not appear to follow any sort of hierarchy. This may be one of the reasons why its use is so powerful and so unpredictable – and so covert.

When analysing public policy, there is an instinctive urge to focus exclusively on the actions and activities of government, rather than on the 'rhetoric'. It is easy to assume that what government does is more important than what it says. And yet the image of public policy could be argued to be at least as important as the substance, if we accept that government's main preoccupation is often with staying in office. The current government is perceived to be extremely populist: 'The extent to which the Government is in listening mode is very low. They listen to public focus groups – an extremely populist government.'(PROV3.Interview 19th August 1999). There has been a general perception that this government is trying to slow down the move towards community care. However this 'backlash' against community care, even the language of their White Papers (Safe and Secure) has had no impact on the actual policy of community care, or speed of discharges and admissions into hospitals or secure units according to a provider chief executive: 'It's perplexing – the government state that care in the community has failed, but

when you look at what has been achieved and what is happening now, there is no move away from that policy.' (PROV3.intterview, 19th August 1999)

The above observation suggests that the government is saying one thing and doing another. Clearly ministers consider that the public can be reassured by stressing the right words, and so researchers attempting to evaluate the success or failure of a particular government policy as it unfolds, without reference to the 'message' and how the public perceives this, run the risk of missing the point. In 1987, Dye commented 'Perhaps that is a weakness in policy analysis. Our focus has been primarily upon the activities of governments rather than the rhetoric of governments.' Policy makers *talk* about policies as well as enacting them. Hence the meaning which underlies this talk needs to be unearthed to discover policy makers' priorities and values. From Lasswell's perspective, politics was conceptualised as 'the process whereby the irrational was brought into the open' (1930) but we could argue that politics and language could as easily be the process whereby the irrational was rationalised. Symbols and language could be tools to manipulate and shape the values of citizens – fitting very well with Lukes' analysis of covert power (1974). A researcher who has spent some time looking at the relationship between symbolic and substantive aspects of policy making is Edelman (1964; 1971; 1977; 1988). His analysis of the use of language by politicians and bureaucrats led him to conclude that the real power in policy making lies in the process of problem construction and articulation through language. Problems were constructed in order to justify solutions, rather than the other way around. Problems were segmented and separated in order that they appear manageable rather than presented as having 'logical and empirical ties to one another.' Examples of this segmentation are found in much of the 'policy talk' of mental health policy makers at the Macro level. When explaining how the quarterly DHA performance review is organised, the lead mental health officer at the Department of Health commented on the difficulties of handling 3-4000 pieces of data. However he noted that 'A sanitised version was made available in the public domain. (DoH. interview, 14th March 1996). This

statement was checked to clarify the word 'sanitised' – did it mean confidential data was left out? The reply was that no, the sanitised version simplified and slimmed down all the data into understandable pieces. The way policies are described also tell us much about how government is shaping solutions and how they wish the public to perceive this. The use of the word 'sanitised' above could suggest that much of mental health activity was 'dirty' and needed 'cleaning up'.

The following four 'labels' in mental health policy making tell us as much about public concerns as government preoccupations. The first example is the Department of Health White Paper (Modernising mental health services, 1998). The public disquiet regarding the speed of discharges into the community over the last fifteen years has been responded to, NOT by the opening of new psychiatric wards, but by a vague policy of community support under the White Paper sub-heading: *Safe, Sound and Supportive.* The second example shows the rather ambivalent attitude towards the mentally ill and the way that resources should be kept safe for them to access. The concept of '*Ring fencing'* funds was on the surface about protecting mental health service assets for mental health users but the underlying tones of 'ring-fencing' suggests keeping things at bay, corralled, separate. Our third example continues with the theme of resources that would be '*targeted'* at mental health service users. This gives connotations of pursuing or hunting, aiming or tracking down. Neither of these two examples gives out positive signals about people who are mentally ill, and denotes that they could be troublesome at best. The final example of policy articulation in mental health comes from the early 1990s, as a sort of backlash to the community care policy. It has been described as the need for people with poor mental health to have some sort of '*Sanctuary*'. On the surface, this may be construed as a place of safety for patients. But then we have to ask ourselves who is hiding from whom? At the Meso level in 2001, a planner commented: 'We still talk about *re settlement* and *retracting*. The concept of 'sanctuary' has gone though, thank goodness.' (DHA2.interview, 20th June 2001). This comment suggests that at least some actors are very aware of the power of language,

and in particular how negative language can colour people's attitudes and values.

When analysing public policy, we have already evaluated the rationale for focusing exclusively on the actions and activities of the providers, rather than on the 'rhetoric'. At a Micro level it is easy to assume that what providers do is more important than what they say. There is certainly much more emphasis on actions, because of the very direct transactions that occur between providers and users of the service: *Fine words butter no parsnips*. However, when we examine the important area of patient complaints, a perennial problem emerges. It is significant that the majority of complaints that the Health Service Commissioner for Complaints in the UK has had to resolve over the last twenty years all centred on poor communication, not apologising for flaws in service, or not accepting responsibility for poor standards. (HMSO, 2000). So, far from words being unimportant, they can make the difference at Micro level between perceived success and failure, between expensive / time consuming litigation and mollified users.

In the policy initiation stage the way issues are described will give policy makers either more or less room for manoeuvre. Much of policy is necessarily ambiguous (Flynn 1990) 'although a policy succeeds as a political device, it may fail to address... the problem' (Parsons), and so Edelman's observation 'words that succeed and policies that fail' suggest that public policy is more about 'doing things right than doing the right thing'. (P Drucker) The use of denigrating language at a Macro level can de-motivate the Micro level actors much more than any policy substance, as one provider chief executive noted: ' No-one has come up with a better phrase than 'care in the community', they are still in search of an alternative.' (PROV.3.interview, 19th August 1999).

All the above evidence has been rather negative and it is important to conclude this section by noting examples of more positive use of language and how this has shaped policy initiation. The two most obvious examples are how we refer to the service and its users. We used to call the organisation a mental

illness service – now it is referred to as a mental health service. Whilst this in itself is unlikely to change the service, it does underline an expectation that people with mental health problems can be 'healthy' and that mental health is a continuum that we all fit into. It is unusual to have people labelled as patients or inmates now. They are more likely to be called clients or service users. They are also more likely to be called by their correct titles and surnames. Newer labels such as 'continued care clients', whilst not ideal, are regarded at least as turning a 'fully closed (institutional) door into a half open one.' (Ramon, 1997: 47).

The above discussion demonstrates the power of language to shape values and perceptions, not just of the 'public' but of managers, politicians, professionals and perhaps most importantly of service users. It is a powerful tool that has been wielded perhaps sometimes unwittingly but with the very clear result of people with poor mental health 'accepting their role in the existing order of things' (Lukes,1974:24) for too long.

Conclusions

At the Macro level, the changes in the composition of agenda setters in mental health services can be plotted on a chronological time trend, commencing with doctors, through non decision making and indifference, to other professionals through the use of new ideas and a elitist approach to policy initiation, to politicians through interests, ideas and a 'policy crisis' and finally to user representatives, through a neo-pluralistic process of consultation, but 'after the fact', over a period of fifty years. Agenda setters exerted power at a variety of levels, but most effectively at the covert level. They were actively involved in pursuing interests, but ideas had a part to play, particularly if there was a crisis or a strong personality at the Macro level and ideas tended to precede interests. But the overwhelming evidence suggests that covert power allied to the use of language was at least as important to politicians as substantive aspects of policy. The evidence suggests that politicians, professionals and managers have been manipulating actors and

using language and symbols to promote change since that early decision point by Crossman, back in 1969. An unlikely coalition of managers and politicians more than any other group have profited by this use of power in the last twenty years. The way that they write policies, the methods for framing research initiatives, the structures that are put into place for funding arrangements and the shorthand ways in which they refer to policy objectives tells us as much about their political preoccupations as their substantive policy choices.

At the Meso level, the composition of agenda setters in mental health services has shifted considerably. The early hegemony of doctors and bureaucrats (as an elite) had changed to a re-energised and re-defined professional group of technocrats, most of who were making real efforts to include pressure groups representing users and carers in the process of policy initiation. All groups were actively involved in pursuing interests, but ideas also had a part to play. There was evidence of quite strong mental health communities or networks at the Meso level, which were not apparent at the Macro level. There was also evidence of significant exchange of ideas between the Meso and Macro level, whilst the presence of a mental health network of planners, clinicians, DHA members, user and carer representatives at the Meso level seemed to dilute the covert methods of power which were potentially available to professionals and planners. There has been more opportunity and time for critical analysis of ideas at the Meso level than at the Macro level, as well as a very robust response to any attempts of the Macro level to impose ideas for mental health working

At the Micro level, we can conclude that policy was initiated in the most powerful sense by the 'early mover' units of the 1980s. However we must not underestimate the impact that later movers had on the policy debate in community care as values and aspirations moved on. The heady days of the 1980s when community care was seen as the ultimate solution gave way to a series of scandals and problems that suggested that ideas would need to be modified and renegotiated. The later movers had to cope with a quite different

set of pressures and intervening factors that were not present in the 1980s. The early agenda setters were individuals who transmitted their vision and ideas for change in a hostile environment. By the 1990s, the moral arguments had been won, and the other factors came into play such as administrative, economic and political concerns. The role of professionals in mental health services has undergone an extraordinary transformation and the old style ward based clinician had disappeared without trace in the space of twenty years. The impact of general management on the policy process had reshaped the way managers and professionals thought about themselves, their colleagues and the mental health service as a whole. Micro level managers and clinicians found more in common and less to fight over, and this process was accelerated by the purchaser/ provider split, which changed the boundaries between health workers yet again. By the late 1990s, the emphasis on partnership, the mixed economy for the delivery of mental health care and the active role of users in planning and evaluating services all suggested an unusually co- operative approach to mental health service delivery but within the space of two years this state of affairs has rapidly changed. The new Government is adopting a more 'hands on' approach and is initiating significant reforms. As the DHAs prepare for abolition and the primary care teams prepare to take over the responsibility for commissioning services, the future looks very uncertain indeed.

CHAPTER SIX:
POLICY FORMULATION IN MENTAL HEALTH SERVICES

Introduction

So far we have concentrated on the process of policy initiation at the Macro, Meso and Micro levels. This next chapter focuses on policy formulation at these three levels: that is how policies are formulated to 'solve' the identified problems. There are a multiplicity of perspectives on policy formulation, some of which are helpful in explaining how mental health policy works, and some of which are less relevant. The three approaches to policy formulation that have been selected for exploration in this chapter have therefore been chosen for their explanatory powers, in the context of policy and power in mental health services. These perspectives are distinctive, in the assumptions about how the policy debate is conducted and how policy decisions are made. From the first perspective, we could view policy formulation as an *output* of purely rational processes. As there are many definitions of the concept of rationality, it is important to stress that the term 'rational', in this instance, is used to denote a policy formulation approach which is systematic, logical and impartial. From the second perspective we could view policy formulation as *driven* by individual interests. From the third perspective we could view policy formulation as being *shaped* by the organisational culture. I have specifically selected three key words to sum up these different views: *output/ driven/ shaped.* The first view indicates that policy arrives (or does not) as a product of a rationale. The second view indicates that policy is presented as a set of pressures and forces. The third view indicates that policy might unfold in a more fluid and less tangible way. In most complex public service organisations, we might see evidence of all of the perspectives outlined above at different times and in different circumstances. There will be times when we see actors making rational policy decisions that flow directly from the objectives that have been set by politicians. There are other instances when we note particular considerations, financial or political, for example, that

actors had to take into account when formulating policy. There are also examples where we see individuals formulating policy that coincides with their own values and interests, whether for advancement, status or sometimes for career survival. Underpinning all these examples is the organisation with its own peculiar culture, built up over many decades, shaping actors and being shaped by them. The three perspectives are not mutually exclusive, in fact they might best be considered through a decision tree approach. We can initially ask whether policy formulation has been rational or not. If policy formulation has been less than rational, we can then ask what individual interests have been brought to bear in the policy making process. If this does not explain the formulation process completely, then we must consider the organisation and its culture(s): what bearing does this wider influence have on the policy process?

How can we identify the characteristics that will tell us whether policy examples fit into our three perspectives? Each of these viewpoints of policy formulation can be broken down into a series of questions that test whether an instance of policy-making fits that particular perspective. So to examine the perspective *policy is a product of a rationale,* we are establishing whether the process of policy making, the actors concerned and the mechanisms (structures and procedures) they use are logical, systematic, and consistent with objectives. We can develop structured questions that can be used to interrogate data in a number of policy-making cases, at a number of levels in the organisation. This will enable us to compare results across time, distance and hierarchy. To examine the perspective *policy is a selective response to individual interests*, we are establishing whether actors' emotions, needs and values affect their policy work. To examine the perspective *policy is a reflection of culture*, we can consider the links and gaps between and within the organisations as well as underlying social structures between people in those organisations, and analyse how these structures assist actors in gaining influence in the policy formulation process. There is some overlap between these perspectives, and of course we will note that different individuals in the same policy case will act for different

motives and with different agendas. Who was successful and why will form part of this analysis. There are links between viewing policy as a response to individual interests, and viewing policy as a reflection of the organisation's culture, because entrenched values, power and interests can translate over time into structures and procedures that harden into a more pervasive culture.

I have considered two main case studies of policy formulation in this chapter. The first one was unfolding in 1983, (PROV1) and the second one unfolded in 1987 (the 'later mover', PROV2). I worked in both of the units and evidence is gleaned from observation and documentation at that time, combined with retrospective interviews. However, I have also included comments from chief executives and planners in 1996 from DHA/ PROV3 (the 'internal market') and in 1999 to 2001 from DHA/PROV 4 ('Under New Labour').

The remainder of this chapter examines these three perspectives of policy formulation at the Macro, Meso and Micro levels. The chapter concludes by considering how the fit between policy examples and the perspectives outlined can help to explain why different levels of the organisation exerted power and influence over the last fifty years, without any one level having a monopoly of control.

6.1 Viewing mental health policy as a product of a rationale: Macro level

Here the assumption is that a policy is calculated to achieve certain aims, goals or objectives, with means and ends 'logically connected and hence mutually consistent' (Levin 1997). It is also assumed that the actors involved are rational, not just in the systems and procedures they select to fulfil the policy but in the content of policy selected. Whilst many writers and researchers consider the debate between rational and incremental approaches to be an artificial one (Smith & May, 1980) or even 'old fashioned', discussions with planners and managers in the NHS indicate that a rational (that is logical, systematic and impartial) approach to policy making is a very important goal towards which

they are constantly striving, in spite of the barriers preventing them from always completely achieving it. The rational approach may seem somewhat unrealistic but in terms of public service planning and delivery, the notion of a logical, consistent and above all equitable approach to policy making is still seen as the 'Holy Grail' by many planners. It is more a long term goal than a short term measure. They all recognise that public services falls short, as noted by the DHA2 planner in 2001: 'Planning is more irrational now, sadly.' (DHA2.interview, 30th June 2001) It is certainly helpful to mark the extent and location of rational activity that may exist in mental health policy formulation processes, as it helps to set the scene for an exploration of how policy formulation works at different levels of UK mental health services, establishing a base line from which other perspectives can be tested.

Within this conceptual framework, two quite different sets of questions can be asked. The first set of questions (6.1.1) is based on work by writers on rationality (see Simon 1957, 1983, 1985 for example) and its main purpose is to highlight any gaps in rationality and to challenge the logic behind policies. Levin (1997) refers to this set of questions as means-end analysis. The second set of questions (6.1.2) then helps us to explore such gaps or inconsistencies, and focuses on ideas, perceptions and considerations that might be in the minds of policy formulators. This is based on work by writers such as Pliatsky (1987), Edwards & Batley (1978) and Levin (1997) and I have called this set of questions subjective-cognitive analysis.

6.1.1. Means-ends analysis

Means-ends analysis challenges the logic behind a policy by 'digging below the surface' (Levin, 1997: 34) looking for clues that the policy formulation process itself was not an inherently rational process. A review of mental health policy at the Macro level in the UK between 1969 and 2000 indicates that the consistent direction over the last thirty years has been to redress the balance in favour of the "Cinderella" mental health services (Hunter, 1992: Chapter 2; Klein, 1989:

Chapter 3). This entailed a move away from institutionalised services towards a more community-based service. If we apply the rational model of decision making to this process, mental health policy needs to be addressed in the context of the options considered at the time, whether policies flowed logically from the objectives and how detailed these objectives actually were. The consistency between proposals and underlying objectives, any selective use of evidence (suggesting flawed rationality) and omissions or un-addressed consequences also need to be taken into account.

Examination of the options considered at the time indicate that there was no evidence of real debate around choices; community care in the UK has consistently been depicted as the only alternative to institutionalised care, despite other countries going for a range of different models (Ramon, 1996). The lack of formal option appraisal suggests a deficit in rationality of policy making. This can be linked back very clearly to the issue of problem definition in policy initiation, as we noted in Chapter Five that professionals were in favour of hospital-based alternatives, but these were not picked up by policy formulators. The policy of care in the community flowed directly from the principles of normalisation propounded by Wolfensberger (1972). These included the right of individuals to live a life as near to normal as possible. Therefore we could argue that despite there being no evidence that alternative proposals were considered, the view that the other hospital-based alternatives did not fit the underlying principles justified politicians in their unitary focus on a single policy option.

The detail and specificity of proposals can be examined through two examples. The first example is based on a consideration of the structures proposed. The second example focuses on the number of beds and day places recommended in the community care policy. In 1985, the House of Commons Social Services Committee confirmed 'its commitment to the development of an integrated network of central and local services necessary for community care, and its priority for mentally ill and mentally handicapped people.' (1985, HC 13-1). The concern was that unless health, local authorities and the voluntary sector

worked together, there would be the risk of duplication of services. These agencies were directed to collaborate through joint planning mechanisms at the Meso and Micro level. By 1988 the DHSS issued a circular (DHSS, 1988) stating that the closure of hospitals was *not* a primary aim, rather that the policy was one of running down and closing those hospitals that were not needed as part of the developing pattern of mental health services locally. The vision from the centre then, is 'reasonably clear' (Hunter, 1992:174). But if we look to government documents for structural detail, there is little to find before 1999. Comments from Hunter, suggest a more incremental approach:

> Psychiatrists and other health care staff are increasingly involved in patients' home settings, working in health centres and primary teams away from their hospital base. Specialist multi disciplinary teams serve the whole district and not simply the hospital... interlocking with health provision, a range of social services are available from residential care through to day care services.
>
> (Hunter, 1992:172)

The above structure has evolved rather than being directed from a central government policy. The centre has used a strategy of 'learning by doing' in the case of community care (Hunter, 1992: 183). Real world practice was informing the policy makers rather than the other way around. The second example of specificity that can be considered relates to beds and day places. In 1975, a total of 0.35 mental illness beds per 1000 population was deemed appropriate by the Department of Health and Social Security (1975, CMND 6233). By 1992 this had been revised downwards to 0.25. By contrast the figure recommended of 0.3 day places in 1975 had been revised upwards to between 0.4 and 0.6 by 1992. (Hunter, 1992: 173-5). The figures for elderly mentally ill (EMI) beds were even more flexible, and were revised by the regional health authorities on a month by month basis in the late 1980s (Personal archives, 1989). The reasons for the shift away from beds and towards day care reflects a change in the *perceptions* by government as to what was becoming possible when caring for people in community. This was shaped by evidence from grass roots services, and, as in the previous example,

real world practice was driving the process. The above evidence suggests that much of the structure and methods of working was left to local practitioners to work out for themselves, and even where specific guidance on the type of service to be provided is identified, this specificity was constantly open to change and re-negotiation.

Any inconsistencies in policy need close attention, as it is possible to find contradictory aims with underlying tensions that reflect a higher or hidden objective. The explicit objectives appeared to fit with the proposed policies, but there have been long running suspicions that the more recent (late 1980s) drive towards community care was less about quality of care and more about cost cutting. Prior to the late 1980s there was certainly a considerable amount of 'bridging monies' for the 'early movers' (Personal archives, 1983). On the face of it, the emphasis was about normalisation and integration, but for 'many of those involved in service delivery, the move to community care has centred on cost containment and on a belief that it is possibly cheaper' (Hunter 1992). In fact a certain amount of 'mystery and ignorance' surrounds the whole issue of costs. The DHSS was compelled to admit to the SS Committee (1980) that hard evidence about the cost advantages of community care has not been readily available. More recently, the work by the Personal Social Services Research Unit, (Knapp 1990) provides evidence, though not conclusive, that favourable outcomes were achieved at lower costs, even after adjusting for the lower dependency early discharges. The above instance, whilst confirming that institutional care was not cheap, does not however really tell us whether a hidden objective behind community care was about resource constraints rather than the stated objectives of normalisation and independence. However, Hunter notes that 'some in central government have insisted that cost is not the key issue and that quality care based on user choice is the objective.' (Hunter, 1992: 168)

If we consider whether there was evidence of bias in the way that facts were selected and interpreted, there was certainly considerable impetus given to the care in the community policy as a result of various scandals in institutions in the

1960s. This led to Royal Commissions urging the move from institutional care towards a more open mental health community. (Rogers and Pilgrim, 1996). Thus the new policy was seen as 'good' and the old policy, and many of the staff within the institutional settings, as 'failing'. However, these demands to move towards care in the community were not necessarily in tune with the prevailing values in society at that time, and there are still significant tensions between society and community care innovators. On the very rare occasions when a person with mental health problems has committed a violent crime, the public reaction has been for a halt to be called to community care, and for mentally ill people to be detained to ensure public safety. (Cohen, 1980:9). And so overall, there was much use of selectivity and disparaging language, as we have noted in Chapter Five, and this manifestation of bias emerged as a direct result of the covert use of power (shaping people's perceptions and values) noted in the last chapter.

Almost all social policy case-studies which examine omissions and un-addressed consequences relate to finance and mental health policy is no exception. The whole process of care in the community led to a quantum shift in expenditure demand from the NHS to local authorities (Jones, 1988). There is scant evidence that money followed patients (Hunter, 1992:168). A further omission in the community care policy relates to the lack of support available for people with very poor mental health in the community. However the early policy of shifting resources into the community in the 1970s on the grounds of providing better and more appropriate standards of care was given a fortunate and unexpected boost with the availability of new drugs enabling people to live outside hospital settings. (Hunter, 1992:168). Without this pharmaceutical revolution, the policy could have foundered very quickly.

By "digging below the surface" we can see, then, that the relationship between the *end* or objective and the *means* or policy to get us there in mental health was reasonably clear if not always consistent. But on some measures of rationality, the process of policy formulation at the Macro level has failed. In order to

discover what other factors affect mental health policy making, and possibly explain why some parts of the policy were less than rational, we need to get inside the minds of ministers and civil servants, as far as we are able, and explore the real world tensions that drive this process.

6.1.2 Subjective –cognitive analysis.

When we reflect on the 'considerations' that might pass through the minds of ministers and civil servants, useful categories that we can consider will include political, practical, financial, legal and ideological ones. (Pliatsky, 1987; Edwards and Batley, 1978; Levin, 1997)

In terms of Macro politics, there has been remarkably strong cross-party consensus over the last thirty years for a policy that enables people with a mental illness to live normal lives in the community as far as possible. This has 'been a central theme in all the health and personal social services priorities documents since their commencement in the mid 1970s' (Hunt, 1992:168). As far as internal politics is concerned, the key challenge has come from the entrenched medical community, (Pettigrew, Ferlie & McKee, (1992:152) a community which is isolated from its peers and perceived as inferior (Klein 1990:80). In terms of presentational considerations, public support for care in the community has always been hard to gauge. There is 'probably a wide measure of support for it in general terms', (Hunter, 1992:170) and at the Macro level, there was less of a 'NIMBY' (not in my back yard) syndrome than at more local levels.

Practical considerations have been defined by Levin (1997: 36) as arising where the world of politics and the 'real world' meet - within the day to day delivery of services. Usually, the discovery of such practical considerations emerges too late for government for them to amend the policy. The policy flaws are only discovered as the policy is implemented. One practical consideration that *should* have concerned ministers (and did not) was how to

support vulnerable people in the community. Fortunately for the government, the availability of new drugs enabled the policy to 'take off' as people became empowered to live outside hospital settings. (Hunter, 1992:168). This is the first example of policy formulation being effective due partly to 'luck' rather than judgement. (Hunter describes the advent of the new drugs as an 'unexpected boost'.) However, we shall see that governments get their fair share of good and bad luck, in these matters. This aspect of 'practical consideration' is probably one of the most neglected areas of study in public policy generally (Levin, 1995) and mental health policy in particular. Whilst progress towards reforms has been 'uniformly protracted and uneven' (Pettigrew, Ferlie & McKee, 1995: 149) very few studies have been carried out to find why this is so. This aspect is considered in more detail in Chapter Seven under policy implementation.

When examining financial considerations, it is helpful to review the trends in hospital bed rates between the 1960s and the 1990s, as this should indicate where and when resources were freed up for re-investment in community services. If we bear in mind that psychiatric hospital bed rates peaked in 1954, the decline was at first gradual. In 1960, 130 hospitals were still open, by 1982 there were 120 hospitals open. This reduction was at its steepest between 1986, with 115 hospitals open, and 1996, with only 58 hospitals remaining open. This reduction levelled off after 1996. (see Appendix F). Bridging funds were only available in the early 1980s and yet this did not slow down the process of closure when it was withdrawn. Financial considerations did not appear to be an overriding factor nationally, though we shall revisit this matter at the Meso and Micro levels. Hard evidence about the cost advantages of community care was certainly not available before the policy was implemented, and even in the 1980s the information was not readily available, as the DHSS admitted in 1980 (1980, HC 702).

Mental health policy has been formulated in the context of significant legal considerations, embodied in the 1959 and 1983 Mental Health Acts. These

oblige professionals and managers to discharge their responsibilities in terms of patient rights. More recently the provisions to compel patients in the community to take their medication, rather than be incarcerated in hospital, is an example of the law following policy rather than policy fitting in with the law. The policy formulated to deal with mentally ill offenders (1996) has been driven by legal considerations.

The ideological concept of community care could be said to have been colonised by a wide range of sometimes opposing factions, a fact which may go some way towards exploring that remarkable cross party political consensus. The drive towards consumerism and rolling back the frontiers of the state by the Thatcher administrations between 1979 and 1993 found echoes in the care in the community policy, whilst the liberal historic emphasis on human rights and more lately the 'community' ethos also found much to admire in it. The general move away from 'institutions' and towards individualist culture was also picked up by user groups. Thus a complex range of stakeholders could consider care in the community to be "their" policy. What is very clear from the outset was that when the problem of institutionalisation was defined in 1969, the care in the community ethos was an 'ideology' rather than a fully fledged policy: 'The adoption of an all encompassing, but vague, community care *ideology* by politicians led to the development of services in the community..' (Ramon, 1995: 24). (author's italics).

On many counts of rationality, mental health policy making has failed. On every aspect of subjective consideration possible, we can see that beliefs, values and political considerations have influenced actors at the Macro level. Although this analysis is unsurprising, it is important evidence to underline, particularly as the Meso and Micro levels have quite contrasting approaches to policy formulation. Now we will consider whether policy formulation at the Meso level is any more in accordance with the rational model.

6.2 Viewing mental health policy as a product of a rationale: Meso level

6.2.1 Is mental health policy ever formulated at the Meso level?

The examination of various Micro provider units shows that mental health services on the ground look and feel very different from each other. Macro mental health policy is transmitted in identical format to Meso level DHA, through White Papers and HM guidance letters, and so we can safely assume that something happens to shape and change these polices by the time they are implemented. But how can we ascertain whether it is at the Meso level or at the Micro level that policies are re-formulated? They may even be re-formulated at *both* levels, and so separating out these influences is important in order to establish who and why policy changes along the way. What becomes very clear when talking to Meso planners is historically how little notice has been taken of Macro plans and how pragmatic the policy formulation process was at the Meso level in the mid 1990s. According to a planner from DHA3: 'Documents do appear, but most action is decided 'on the hoof' ... there is an enormous gap between the theory and what we actually do.' (DHA3.interview, 4th June 1997). There is also evidence of some resentment when senior Meso planners are obliged to follow Macro direction that is not perceived to be either rational or practical: 'Silly fashions which are often promoted centrally come into play ...tedious and silly' (DHA3.interview, 4th June 1997).

The implications of the above quote suggest that the 'fashionable' policies handed down from the Macro level are not perceived as workable at Meso level, and so the policy will necessarily be changed or ignored. This is justified by Meso planners who feel closer to the 'real world' of users and their needs as noted by the DHA2 planner: 'The needs of users don't change **that** much, just the language. There is a tendency to believe that the NHS has changed more than it actually has.' (DHA3.interview, 4th June 1997).

However, there is evidence of significant erosion of this freedom to formulate and re-shape at the Meso level over the last three years, as noted by a planner from DHA2 in 2001: 'Now it's SO prescriptive. Down to the number of staff needed in a crisis team. Would have been different in the early 1990s.' When asked how much discretion the Meso level now had, she continued: 'Discretion? We have always taken the 'policy' and got on with it. We don't question/ kick against, we're very pragmatic, do what we're told... Previously there was emphasis on principles and values but the detail is new, drawn from both local good practice and national initiatives'(DHA2.interview, 30th June 2001).

The above cases point to DHAs having been actively involved in re-formulating and making sense of Macro policies until the late 1990s. It seemed to be a large part of their work. Discussion with a regional outpost director for mental health services in 1997 confirmed these findings across the whole of one region: 'Big Vision' planning has disappeared, but most planning is going on at DHA level. Strategy is formulated at purchasing level but has to follow national guidelines and strategies.' (RHA1.interview, 1st November 1997). However, the tensions between local and national needs are much more evident as we examine the recent, more controlling approach from the Macro level. When asking a DHA2 planner about the logic and consistency of Macro policy making she replied:

> It's more irrational now, sadly. Local priorities are over ridden by national agenda. For example, counselling has some good evidence-based results and we would like to have it in all general practices (for equity) but it's not a national priority. It may not be an 'acute' issue, but it is part of prevention. There is also a lot of rhetoric on user involvement and we want to steam ahead on this, but again it's not a national priority.
> (DHA2.interview, 30th June 2001)

So, Meso planners believe that an inflexible approach to policy formulation can create internal contradictions and reduce the rational nature of planning *per se*. Despite the more recent evidence, we have established that the Meso

level has traditionally been actively involved in formulating mental health policy, and we can now look at the rationality or otherwise of this process. The process of policy formulation at the Meso level can be examined as at the Macro level by paying attention to the procedures and systems used to make policy as well as the links , if any, between objectives and the final policy. The two sets of questions used in the last section are revisited: means-ends questions, and subjective-cognitive questions.

6.2.2. Means-ends analysis

At the Meso level, we can start by asking, again, whether *alternative proposals* were considered. If we examine early policy choices in the 1980s, in the 'early mover' DHA1, we can see that re-provision of services in anything other than community based models were not considered: 'We (supported by the DHA) decided to cut our losses, and go for community based services. We knew we were doing the right thing.' (Prov1.int.3.11.00). And 1987, in another district, (DHA2) we can observe that there was still very little room for manoeuvre. Following the DHA Review with the Region on 5th October 1887, and a Health Advisory Services visit, it was agreed that the DHA would, jointly with the Local Authority, produce a revised strategic plan for mental illness services. However the choices were limited; the Plan was to include the following components:

> The build up of a network of community based services, which would eventually lead to the replacement of the facilities currently on one of the two large mental illness hospitals in D. The DHA confirmed the view that it was preferable to work towards the ultimate replacement of the existing services at *P* Hospital in advance of those on the *K* site.
>
> (DHA2. Strategic plan. December 1987)

Alternative proposals were not considered, and the reasons for the decision to close one hospital rather than another were not discussed or documented.

If we then consider whether the policies *flowed logically* from the objectives, in DHA2 we come to a dead end, for the DHA had discharged its responsibilities for policy formulation with the above guidance. The remainder of the policy formulation process then occurred at the Micro level and apart from the DHA planning officer attending the occasional meeting, the Micro level was left to get on with it. The Chief Executive noted: 'No control at all from the DHA. Left to my own devices. They weren't interested unless there was a complaint.' (PROV2.interview, 3rd July, 2001).

The details and *specificity* of proposals and objectives in DHA2 were expressed through two documents; the guidance noted in the quotation above from the DHA in December 1987, and Advance Letter HC(FP)LAC.Jan.86. The Advance Letter issued by the Department of Health gave detailed guidance on the required membership of planning teams and groups, as well as less specific guidance on methods of working. The following extract gives an idea of the hopes and aspirations of the Macro level, as well as their assumptions about what was deliverable:

> In advising on joint planning, the teams will need all available information on total resources for the client group among the statutory authorities and other agencies, the ways in which the resources are deployed and adequate assessment of client needs, current and future. The teams will need to know of gaps and unnecessary duplication in services and of problems currently experienced by clients and staff. They should then draw up plans that are feasible within likely future resources, are flexible enough to cope with the fluctuations in resource levels and optimise the use of all resources.
>
> (Section B.12. of HC(FP)LAC.JAN.86)

I observed staff at the Meso and the Micro levels throwing their hands in the air and asking 'What planet are they on?' (Personal archives. 1987). The community services that had been set up were small and frail. The chances of them being able to deliver a fraction of the above demand were seen to be very low indeed. Expectations were very high, but detailed guidance (apart from the membership requirements) was less clear. This lack of clarity in the proposals

means there was also the risk of a lack of consistency between these and the underlying objectives.

The use of *blaming/* disparaging language appeared fairly widespread in the NHS. Most of the 'blaming' tended to gravitate upwards: when the early mover was struggling to close its institutions, the Chief Executive stated: 'They (Region) hadn't a bl** clue.' (PROV1.interview, 3rd November 2000). When there was a Micro level crisis in PROV2, the Chief Executive said: ' Region behaved like pigs. Concerned only to save their own skin.' (PROV2.interview, 3rd July 2001).

Meso level planners in DHA3 talking about the review mechanisms with the Department of Health stated: 'In reality, it is all a bit farcical'. When discussing how planning works, a Meso planner in DHA4 noted: 'We do have a planning department which produces plans. No-one looks at them.' (DHA4.interview, 26th June 1998). The language is important to note because it indicates significant conflict between the different levels of the organisation, and allied to that a lack of understanding of the other party's objectives.

When we consider whether there were any *omissions or un-addressed consequences*, the issues that emerged depended very much on chronology. The 'early mover' DHA1 in 1983 had to struggle with the lack of joint planning arrangements with social services: 'In hindsight I would have put more effort in here' (PROV1.interview, 3rd November 2000) and unforeseen financial burdens on the Department of Social Security as discharged patients became entitled to social security payments By 1997 the focus had changed according to the planner in DHA3:

> There are huge problems in measuring clinical effectiveness, there is no hard evidence. We are always trying to write strategies before obtaining all the information required. There is also the problem of guidance nationally which may be imposed regardless of effectiveness. For

example the Care Programme Approach may lead to worse outcomes as paperwork increases at the expense of face to face contacts.'
(DHA3.interview, 4th June 1997, ctd 19.6.97)

These later omissions and un-addressed consequences give cause for concern, as they touch on such fundamental issues that cannot easily be put right. In an organisational learning context, the NHS seems to be going backwards rather than forwards.

By "digging below the surface" we can see that the relationship between the *end* or objective and the *means* or policy to get us there in mental health is somewhat clearer and more consistent at the Meso level than at the Macro level. On most measures of rationality, the process of policy formulation seems to score higher at this intermediate, bridging level of the organisation. This evidence fits quite closely with the policy initiation process noted in the last chapter. Meso level actors appear to have developed enough 'expert' knowledge and information to be able to make more 'rational' decisions than Macro level officials. The Meso level also appear to be more removed from the political pressures that have constrained the Macro level officials, who reported directly to Ministers, although this was not the case for social services officers at the Meso level, who also were also accountable to politicians. But in a chronological context the picture is bleaker. By the mid 1990s the Meso level perceived itself to be under siege from fashion and political directives from the centre, and by the late 1990s, the centre was controlling the detail as well as the general direction of policy. The policy of 'benign neglect' that appeared to be the attitude of the Macro level to the Meso level in the mid 1980s had all but vanished fifteen years later. Other factors were changing relationships between the three levels, and the next section explores some of these, including the real world tensions that drive this policy formulation process.

6.2.3 Subjective –cognitive analysis

When we reflect on the 'considerations' that pass through the minds of Meso level planners and managers these could again include political, real-world, presentational and financial considerations. *Real world* considerations could include responding to changing events locally but also nationally and this is certainly the case in three districts. According to the DHA3 planner 'Everything we do is extraordinarily pragmatic.' (DHA3.interview, 4th June 1997). The DHA4 planner noted the gap between plans and real life: 'We do have a planning department which produces plans. No-one looks at them.' (DHA4.interview, 26th June 1998). However, when I asked him if his department took a pragmatic approach to policy formulation, he frowned and said not – and that the purchaser-provider split had placed the onus on the DHA to be much more proactive. Three years later, there appears to be an almost fatalistic approach to policy making and discretion. According to the DHA2 planner: 'Discretion? We have always taken the 'policy' and implemented it. We don't question/ kick against, we're very pragmatic, do what we're told'. (DHA2.Interview, 30th June 2001).

Political considerations could include the relationships with local pressure groups as well as the link with the Macro level. Some of these relationships are documented but others are more difficult to establish. The DHA3 planner noted that 'It's complicated, there are formal procedures as well as informal.' (DHA3.interview, 19th June 1997). Formal procedures in the districts include joint planning groups, and in DHA3 a purchasing for users group was set up in 1992. However, some clinicians were less concerned with political considerations, and the groups convened by doctors were noted for their lack of user involvement: 'It depends who convenes the group. For instance a medic might convene a totally user-less group as they would use a different network. Practice is still rather shaky.' In the early 1990s in DHA2, the views of users were rarely considered, as noted somewhat ironically by their planner: 'Even back then, in 1990, we created working groups which were a mixture of DHA

and provider staff. Not consumers, good gracious me no!!' (DHA2.interview, 30th June 2001).

Presentational considerations are more likely to reflect a preoccupation with the views of the public as well as specific user groups. The following example cited by a planner in DHA3 demonstrates the gap between content of policy and rhetoric:

> The NSF (National Schizophrenia Fellowship) are never slow in coming forward. They would demand and get a meeting with the Chief Executive, for example over the new drugs for schizophrenia which are more expensive and effective but have more side effects. The Chief Executive organised a study day to debate the issue. Everybody said their piece. Nothing changed but honour was satisfied through the very visible debate.
>
> (DHA3.interview, 19th June 1997)

What we can conclude from the above example is that although managers and planners at the Macro level did take into account political and presentational considerations, they were able to continue to formulate policies of their choice, based on their perceptions of 'rationality.' They achieved this through losing, changing or ignoring Macro policy advice, as discussed in the beginning of this chapter. They also acknowledged and encouraged pressure groups to use 'voice', but did not follow up their concerns where they deemed it inappropriate. Doctors also exclude users groups from the decision making process *per se.*

Managers at the Meso level are of course affected by *financial considerations*, but not perhaps as much as would be expected. In 1987 in PROV2 the local strategic plan was finally approved by the then RHA, but they 'declined to assist with bridging funds' (Personal archives). This news came as a real bombshell to providers, and the whole status of the Plan was thrown into question. However, the Meso level managed to raise the finances necessary through the sale of land and partnerships with local housing associations, demonstrating their commitment to the strategic plan, despite financial difficulties that they were in generally. The above case study demonstrates that financial considerations,

whilst playing a part in the Meso level negotiation process, was not a fundamental block or barrier for policy action in that district.

The Meso level is driven to a certain extent by political, presentational and financial considerations but by no means as much as at the Macro level. Theories and ideas however can be very powerful levers for policy formulation at the Meso level, as well as policy initiation as we have already noted. If we wish to consider why these considerations affect individual managers and planners at the Meso level, we need to establish the interests that drive and motivate their actions. Before this, we will consider how rational the policy formulation process is at the Micro level.

6.3 Viewing mental health policy as a product of a rationale: Micro level

6.3.1 Is mental health policy ever formulated at the Micro level?

Mental health services at the Micro level have traditionally not been noted for their homogeneity in structures or patterns of delivery. We know that there is significant re-shaping if not ignoring of Macro policies at the Meso level but how much discretion do providers at the Micro level have to make and change policy? There is potential for policy re-formulation, either by default as they implement something that nobody has planned, or by design, when they are formally consulted by the Meso level about plans and services.

Chronology is particularly important here. In the early 1980s, providers who were 'early movers' had a surprising amount of discretion in the services they planned and the processes to get these plans implemented: 'Discretion? Complete and absolute.' (PROV1.interview, 3rd November 2000.) In the late 1980s, providers were also expected to formulate plans. In PROV2, following the District Review with the RHA in 1987, it was agreed that the DHA, jointly with social services, should draw up a revised strategic plan for mental illness services. However, this process was delegated to the delivering unit, with very

occasional visits from DHA planners to the steering group meetings. (Personal archives, 1987). By the 1990s the purchaser/ provider split between the Meso and Micro levels had been created. When the early DHA purchasing teams were set up, they had few members who had the skills and knowledge necessary to challenge what providers had decided to deliver, as the DHA3 planner noted:

> As a specialist I feel we should be taking the lead and setting up adequate mechanisms for monitoring. 'Let the provider lead the way' is the view held by other colleagues. Providers could run rings round some purchasers! ... We have never really had a period of consolidation, to be tooled up and trained for the job. Technical skills are important but because relationships are not clear, interpersonal and leadership skills are absolutely critical. Previous and current chief executives are not comfortable with handling issues to do with style, emotional or interpersonal skills. Public health planning requires specialist knowledge and skills but negotiating skills are crucial.
>
> (DHA3.interview, 4th June 1997)

But there is evidence of a sea change, in the last few years. When asked to describe relationships with providers by 1998, a Meso level planner stated: 'This has changed a lot. Purchasers should be involved in thinking through strategies and providers should focus on doing. There have been problems with the thinking capacity in the past. Until eighteen months ago, the services were provider led. Things are changing now.' (DHA4.interview, 26th June 1998).

And the provider perspective in PROV3 was changing too:

> There have definitely been shifts. All money is targeted (very little discretion here) and there is a big emphasis on delivery, including more follow up and monitoring ... we have to deliver on what the Department of Health demands, this is the bottom line. But the requirements for the bottom line have grown hugely, with all the new performance measures; that does not leave you much discretion!
>
> (PROV3.interview, 19th August 1999)

The above evidence all points to the Micro level having significant discretion to change and re-shape policy at the beginning of the 1980s but this has been

slowly eroded over the intervening years. NHS–wide re-structuring as well as the more recent growth in performance measurement and outcomes led by a new government is squeezing mental health service providers as much as their counterparts in the acute services according to the PROV3 Chief Executive: 'The Third Way is not the command and control economy, nor is it a market economy. It's based on performance management and outcomes, holding people to account.' (PROV3.interview, 19th August 1999). When he then went on to state: 'I am a fairly compliant individual – a public servant – tend to follow the government line' I wondered how widespread these attitudes were. However, discussing this issue of discretion with a chief executive in PROV2 not noted for his compliant attitude over the last twenty years, he gave a hollow laugh and said: 'By 1998 you could hardly move without the Region breathing down your neck. We had our performance managed from the RHA and monthly visits.' (PROV2.interview, 3rd July 2001)

Hence the reduction in freedom to formulate policies at the Micro level appears to mirror the erosion that has occurred at the Meso level. The Micro level has been involved in significant policy formulation until very recently, but the last three years has seen a reduction in this process. However, it is still important to establish how rational policy making has been at the Micro level until recently, as this may have a bearing on the recent take-over of the Macro level in shaping policy.

6.3.2 Means-ends analysis

If we consider whether **alternative proposals** were considered, in Prov1 ('the early mover') the decision to move towards community based services was an ideological one, backed up by the decision to 'cut our losses' (int.PROV1.) The services were so poor, that it seemed simpler to start again than to struggle to improve existing services. There was no evidence of other proposals. In 1987, in Prov2, there was an assumption in the DHA briefing that there would be a network of community based services which would replace a named

hospital. The policies of community based services seemed to *flow from the objectives*, although Prov2 identified a problem with the 'viability' of objectives with the proposed rundown rather than closure of a hospital. The quality of the resulting services in the run down hospital had become an issue. The physical environment was poor, all spare finance was spent on basic health and safety repairs and the Chief Executive felt that he was being starved of resources: 'As beds closed and services retracted, the DHA kept the money and I believe this went into the acute units.' (PROV2.interview, 3rd July 2001). In Prov2, in 1987, a paper entitled 'Principles of a Community-based Service' written by the Unit Psychologist was used as a benchmark to test plans as they evolved. The process of local planning was decentralised, although a Local Planning Support Team was set up to link between the DHA and the locality planners. All the key components of the plan appeared to fit in with the objectives stated in the *Principles* document: the concept of a flexible mental health services network, the new criteria for clients (less dependent, more dependent and acute short intensive treatment clients), enhanced domiciliary support. Overall, the act of drawing up a guiding set of principles which embodied values as well as processes for inclusion of key groups enables a whole range of agencies and localities to plan services that flowed logically from the objectives. The details of the objectives were very clear and consistent in PROV2 because of this guiding set of principles. The *specificity* of objectives became problematic however, when the issue of beds was discussed. The RHA kept revising the number of elderly mentally ill (EMI) beds downwards, which had serious implications for supporting EMI clients in the community.

There was evidence of selective use of evidence and some disparaging language, when we examine the relationship between the local planning groups (LPGs) and the hospital staff in PROV2. With planning groups operating n both areas, the potential for confusion and duplication was high. Whilst the Local Planning Groups were fairly mature groups who worked reasonably well together, the hospital groups had been hurriedly set up. This

was partly so as not to leave them out and partly as a sop to medical staff who still expected the service to be planned along the lines of their own specialities, namely acute, rehabilitation and elderly services. These hospital groups tended to be dominated by senior professionals who had been unable to get involved in the LPG activities. Thus they tended to represent the more conservative school of thought within the hospitals and with no chance of cross fertilisation with any community workers, they became isolated and ineffective. No junior hospital staff were included in these groups and this further alienated the 'grass roots' hospital services. (Personal archives, 1987). This use of *blame/* disparaging others, whilst suggesting that the policy formulating process was not particularly balanced or even- handed can be explained by the shift in power from the institutions to the community and the resultant conflict that this engendered. As far as *omissions and un-addressed consequences* were concerned, in PROV1, they discovered that the most vulnerable clients could be forgotten, as noted by the Chief Executive: 'We weren't always clear enough about what services were for. The most severe and enduring illnesses were not targeted enough.' ((PROV1.interview, 3rd November 2000). The main omissions in PROV2 concerned developments outside the strategic plan. For example, no thought had been given to the problem of adults and youngsters who self harmed, and in fact it was the General Hospital's Accident Unit that identified this trend, that was then addressed through the contracting process by the DHA.

There is some evidence that the process of community care planning became less rational as the later mover (PROV2) attempted to plan its new services. There are certainly many examples of constraints and pressures that the officials had to pay attention to at the Micro level, that were not even considered in the 'early mover' case. However, there are enough gaps in rationality in both cases to merit looking closer at other factors that affected these two policy formulation studies.

6.3.3 Subjective –cognitive analysis.

When we reflect on the 'considerations' that passed through the minds of Micro actors, these might again include political, presentational, practical, financial, legal and ideological factors. One might expect that at a Micro level, ideology and politics would play less of a part in decision making than practical and financial considerations. However, this was not always the case.

In PROV1, there was very little interaction between health and other agencies. The level of discretion was significant (absolute?). However, by 1987 in Prov2, there is evidence of more political pressures from other agencies. (Personal archives, 1987). Since 1986 a jointly run (health and social services) project has provided and developed services for people with poor mental health. The presentational considerations seemed to be quite low in the early mover (PROV1), according to the Chief Executive at that time, although there is evidence of significant advance planning in the receiving locality in this early case:

> For example in Torbay a joint plan for services for mentally ill people has been in operation for some years... The plan evolved locally through close so-operation between those involved. As a result a common sense of ownership is shared by staff who are committed to its successful implementation.
>
> (Hunter, 1992: 181)

If we examine practical considerations that might have passed through the minds of Micro actors, we discover that although these might have been relatively numerous in the 'early mover' PROV1 case, they did not have much of a bearing on the policy formulation *process*. PROV1 managers had poor relations with medical staff (with one exception), no experience of hospital closures and re-provision in the community, the estate was crumbling and support from above the Meso level was non existent. (Personal archives, 1983). All these factors did not prevent policy from being formulated at this level, in conjunction with the Meso level. In fact the Chief Executive stated during an

interview that these factors were used to help drive the changes. (3.11.00). The crumbling estate allowed management to close whole sections of the institution, the warring doctors were left to fight amongst themselves and the lack of interest at the Macro level gave the 'early mover' great freedom. In the later mover case (PROV2) similar factors were reacted to very differently. When the Health and Safety Executive issued a critical report on various aspects of the hospital, the response by managers was to pour all their spare resources into patching up these problems. This led to a unfavourable report by the District Health Authority on other aspects of service, and the chief executive responded as follows: 'I was summoned to account, and I took all my non-recurrent expenditure details with me. Every single one related to essential Health and Safety repairs. (0pen drains in kitchens etc.) I believe pressure was then put on DHA officers to provide extra resources.' (PROV2.interview, 3rd July 2001). Other practical considerations in PROV2 included which hospital to close (there were two), and how to place ('*repatriate*') former patients in the outlying communities. What is very interesting when examining these factors, is that some of them became 'political' considerations. The issue of which hospital to close was eventually decided by the Regional Health Authority, whereas the question of 'repatriation' was left to the hospital and occasionally the patients concerned. Decisions about individual patients' lives appeared to be less 'political' than boundaries and catchment issues for hospitals.

Financial considerations became more important as time went on. The early mover had significant bridging funds, and a guarantee of no-redundancy for the affected hospital staff. By the late 1980s in PROV2, the bridging funds had dried up, although the new mental illness specific grant (MISG) shaped policy significantly. This grant was only available for joint health and social services projects and compelled agencies to work together more closely in providing multi agency services. The day to day legal considerations that crop up at the Micro level tend to revolve around the rights of individual patients enshrined in the 1983 Mental Health Act. These did not appear to have a major impact on the policy formulation process. However, as patients were discharged from hospital,

supervision orders were implemented in order to keep track of vulnerable clients.

It is possible to infer from the discussions with the early movers that the concept of community care was ideologically driven by values of normalisation and anti-institutionalisation. The policy that emerged in PROV1 may superficially appear to have been driven by practical factors such as the poor state of the existing services and the decision by managers to 'cut their losses'. However, the motivation to close the hospital and to improve conditions for existing patients in a more 'normal' setting shaped every action by these managers. Any discussion on keeping or preserving the status quo was heavily criticised, staff who did not want the hospital to close were excluded from policy discussions and were less likely to be promoted and rewarded. The same pattern emerged in PROV2 in the late 1980s. The senior managers involved in planning the new community services had offices within the grounds of the hospital but there was almost no communication between the sites. Meals were taken separately, the community meetings did not include hospital staff and even the conditions of service were different. (Personal archives, 1987). By the mid 1990s, there was probably less ideological polarisation, because the transition from hospital to community was complete. The concept of community care was now the accepted status quo and the arguments had been won.

Summary to viewing policy formulation as the product of a rationale.

The policy formulation process at the Micro level has not been typified by a completely rational approach. The considerations that managers have dealt with have changed over the intervening period. Ideological considerations probably shaped the process most in the beginning (with PROV1 particularly and to a certain extent PROV2.) The other considerations such as political and financial have emerged more recently. Perhaps the most important point to note from the preceding analysis of 'considerations' is how a practical consideration can very

quickly become a political one. When this occurs, the Meso level tends to get more involved. Thus, managers' discretion for formulating and managing policy issues will be partly be dictated by the definition of what is a practical problem, and what is a political problem. There is some overlap here between policy formulation and policy initiation. We have already examined how issues turn into problems, and the process of defining political versus practical *considerations* can have an impact, not just on how policy is formulated, but how problems are re-defined.

Overall, the policy formulation process appears to have been at its most rational at the Meso, linking level, although there have been gaps and inconsistencies here as well. But not all of these are explained by considerations that affect the policy formulation process. We also need to consider how actors affect the policy process as individuals: what motivates them, their values, emotions and interests. The next sections consider this rather different view on policy formulation.

6.4 Viewing mental health policies and measures as selective responses to individual interests

This alternative view on policy formulation can expand our understanding of how individuals behave in the policy formulation process. Some writers combine rational approaches to policy making with the role of individual interest. For example, Dunleavy writes that the rational actor model in the public choice debate assumes that 'people are maximisers who always seek the biggest possible benefits and the least cost in their decisions' (Dunleavy, 1991: 3). However, the preceding view of policy formulation as a rational process has been predicated on the assumption that rationality is based on the needs of the organisation rather than the individual. Policy formulation is treated as an intellectual exercise, the objectives are taken as a 'given'. The subsequent view on policy formulation as a response to individual interests is quite different because it examines who stands to gain or lose from different policies, or, as

Levin puts it colloquially: 'what was in it for them.' (1997: 38). The motivations which drive actors will be considered in this section, and will include individuals' feelings and emotions, their need for power and status, and their individual values in allocating resources.

Whilst most attention will be paid to the officials, managers and planners in the mental health policy process, the important role of consumers will also be examined. Some writers argue that when new policies or proposals are mooted, the interests of consumers are debated publicly and openly (Levin 1997: 39) though this view is not shared by Allsop : 'In the past, users of (NHS) services have tended to accept what they were offered' (1992: 50). In the case of mental health services users, the picture is uneven. DHA1 has a community based mental health services which resulted from wide consultation, but the sheer complexity and range of agencies now providing mental health services makes monitoring difficult. 'More than ever ... users will have to rely on active pressure groups to campaign on their behalf and to keep health issues on the agenda'. (Allsop 1992: 166) We have already noted in Chapter Five that users and their advocates became more involved in planning services at the Micro level in the early 1990s, but this was followed by the contracting process and the NHS internal market. This gradually re-focused power and information at the Meso level over the subsequent years and so user input at the Micro level became less effective.

The other category of interest has been referred to as 'political/institutional' (Harrison, Hunter and Pollitt, 1990; Klein 1989) - people who 'stand to gain or lose in terms of their position in the world of government or politics' (Levin 1997: 39). If the debate on consumer interests is constrained, there is even less discussion about this second category of interests. Sometimes we may see an alignment of the two sets of interests (for example where a pressure group is campaigning for a policy that would also reflect well on the government). Hence the decision to subsidise groups such as MIND, the pressure group concerned with improving conditions for people with poor mental health. When

discussing this relationship with the senior civil servant responsible for mental health in the UK the tensions were uncovered even further:

> It's not my job to manage them (pressure groups) but it can be advisable to shape their behaviour ... Ministers would expect me to know what PGs are thinking. They do the craziest things ... we fund £2.5M of projects and yet the Mental Health Foundation will criticise government policy the *very week* that the next year's budget is decided! Our role is often to smooth during this process; Ministers' immediate reaction is to cut them off.
>
> (DofH.interview1.14th July 1996)

Government's deeper interests may best be served by what seems on the surface to be a very public conflict: 'This decision may seem perverse: why should Ministers use public money to finance an organisation whose aim was to embarrass them? But the encouragement of this group makes perfect sense once it is recognised that Ministers needed allies.' (Klein, 1990: 81). This alignment of interests, between the organisation and other pressure groups is therefore subject to some strains and stresses, and though perceived as a political 'fix' appears to be 'smoothed' by the civil servants and officials at times of stress. What does this tell us about mental health interests? It suggests that organisational, individual and external interests are all distinctive, though occasionally overlapping. It also suggests that overt interests, in this case the government being seen to be in control, can be 'traded' or 'subsumed' for other interests, in the pursuit of a deeper interest. This deeper interest can be identified as the longer term support of a pressure group which is completely committed ideologically to community care.

So when we examine different interests held by different actors we will be viewing them at two levels, consumer interests and internal interests of officials, professionals and managers, and noting that these interests, though diverse, may overlap at times. As mentioned above, there is very little discussion on these 'internal' interests, and the conception of interests 'poses at least two difficulties' (Ham & Hill, 1993: 73). These are, namely, that actors do not always appear to act in what could be perceived as their best interests (for

example staff closing down a hospital which provides them with employment as in PROV1.) The second difficulty is that we can infer interests from expressed preferences that form an overall consensus, but we do not know if the interests are driving the consensus, or the consensus is 'false' and masks competing interests. Writers have attempted to distinguish between 'subjective' and 'real' interests by linking this debate to an analysis of power in the local community (Polsby, 1963: 221) and Lukes' view on covert power (1973: 23) does take into account the possibility of individuals' preferences and wishes being shaped by leaders as we have noted in Chapter Six, Section Five. So examining policy formulation as a selective response to interests will need some 'digging beneath the expressed policy preferences to discover the underlying private motives' (Levin, 1997: 38). This can be undertaken by assessing who made a mark on mental health policy, who gained and who lost as a result of the policy that was formulated. A combination of documentary analysis and historical evidence will go a long way towards answering these questions, although finding out the real interests of individuals will always be an incomplete activity. However, by identifying the actors who 'lost out', we can at least indicate those who were forced or who chose to give way. Identifying the 'gainers' will also indicate which actors appeared to be able to control events, though, even in this case, we must never exclude the possibility of luck or, when relying on memoirs, of hindsight!

It is worth concluding this general section on interests by referring to Alford's work on health interests. (1972: 64). He considered that there were, in the 1970s, at least three distinct types of structural interest within the NHS: dominant, challenging and repressed. Alford noted that the medical profession dominated the NHS. Consumers would normally be classified as the repressed group and the challenging group could be construed as managers. However in mental health services the picture is more complex, particularly if we view this concept of interest over the last twenty years.

6.4.1 Selective interests at the Macro level

In this sub section we will be considering whose interests made a mark on mental health policy in the sense that they stood to gain from it... and whose interests made no mark in the sense that they stood to lose throughout. At the Macro level, we have already noted that the view of professionals (that services should be relocated in general hospitals) was ignored and that the views of newer and emerging professional groups such as psychologists, and the influence from the USA and Italy, of re-provision of services in a more 'normal' community setting made much more of a mark on policy.

In 1969, the civil servants' views at the top of the organisation (to not publish the findings of the Ely Hospital Enquiry) were overridden by the Secretary of State for Health. When we consider whether the proposed mental health policy specified groups of patients who would gain or lose, the policy guidance suggested that 'every user would benefit from a modern, personalised community service', and no potential consumer losers were identified (Nodder Report 1985, Care in Action DHSS 1981a, and the Social Services Select Committee Report on Care in the Community DHSS 1981b). We note that 'the only group of major stakeholders not to criticise hospitals and hospitalisation were/are relatives ... who are obviously keen on retaining a space that lets them off the hook both ideologically and practically'. (Ramon, 1996: 28) Certainly some user groups at a national level have been critical of the speed of discharge and the inadequacy of community services and are still pressing for re-hospitalisation at a national level (for example the pressure group: 'Schizophrenia, a national emergency' SANE.) Although much media attention is paid to these groups (Ramon, 1997: 50) there has been no reverse of the trend to close psychiatric beds and so we could conclude that this type of pressure group has 'lost out'.

6.4.2 Selective interests at the Meso level

Generally speaking, the 'gainers' in the mid 1970s were the new professional officers, post 1974, who were given significant new responsibilities and freedoms. Lay members of health authorities were 'restricted to a policy approving and monitoring role leaving detailed management and the formulation of policy to officers' (Brown 1975: 203) and as such could be construed as 'losers'. But if we note two specific DHAs, there are chronological differences. In DHA1 (the 'early mover') the actors who made a mark on policy were the District Administrator and his deputy who drove the whole process of community care, whilst the 'losers' in this DHA were perceived to be other general health services, who did not receive funding or modernising influences to the same extent. It was certainly one of the few DHAs where attention was paid to what was generally regarded as a 'Cinderella' service. In DHA2, by the late 1980s, the gainers as a result of policy were the acute general hospitals, initially at least. As beds closed in the mental illness unit, some of the resources were lost in the general DHA pot, according to the PROV2 chief executive: 'As beds closed and services retracted, the DHA kept the money and I believe this went into the acute units' (Int1.PROV2.3.7.01). It might be expected that the general practitioners would be in a position to enhance their domain, but perhaps the shift of responsibility was perceived as a poisoned chalice. Research on GPs' attitudes to people who present with mental health problems in the UK and Spain suggests that GPs have grave concerns on how to respond to individual cases, and how to cope with this rising tide of people in the community with poor mental health. (Hurford, unpublished MSc thesis, 1991). These findings date ten years after many community care systems were implemented, and so this could not be construed as a short term problem for GPs. Social services could be considered as 'gainers' as they became more able to access mental health funds and shape policy, but senior officers in social services (DHA1) were not involved at all in the 'early mover' process, and were pessimistic from the start in the later mover (DHA2.) (INT1.SS.Meso2.9.89.) They feared that

they would be given responsibility without adequate resources. There were also significant differences in their discretionary powers in allocating resources. In DHA2, anything more than £1000 had to be cleared through social services committee (1988) whilst they observed hospital managers casually assigning £10-20 000 to new projects. This created significant tensions within joint planning forums (personal archives, 1988) and is still reflected in the use of language by health staff, as we see from the comments of the PROV1 chief executive: 'The social services continued to be paupers' (PROV2.interview, 3rd July 2001). More recent losers identified by a DHA2 planner in 2001 were the non statutory sector who were struggling to provide services in competition with the NHS units. 'There are gainers and losers. Some of the non statutory providers miss out' (DHA2.interview, 30th June 2001).

6.4.3 Selective interests at the Micro level

As mental health policy has unfolded, the vested interests for defending the status quo in PROV1 came from staff within the institutions who were concerned for their jobs and way of life, which included subsidised housing, transport and social life. Residents in the local area to the hospitals closing would also lose significant business. (Personal archives.1983). Other 'losers' would be the 'old guard' medical divisions; consultant psychiatrists have long held a lowly place in any hierarchy of specialists (Strauss et al 1964.) Klein notes: 'in terms of the medical profession's ladder of prestige, the specialties in the long stay sector were at the bottom of the hierarchy.... weakness was self enforcing: given their lack of prestige, (they) were in no position to assert their claims to more resources effectively' (1989: 80)

The new roles and responsibilities assigned to members of the community mental health teams in the late 1980s would suggest that these were 'gainers' not least because of the higher nurse grading in the community, as noted by the chief executive in PROV2: 'Recruiting community jobs was popular because it was prestigious and better paid'. In PROV1 as well as PROV2 this change

impacted on staff running the retrenching services, who perceived themselves to be less valued and probably were, if we bear in mind that the flow of staff from hospital to community was steady and tended to be the younger, better trained staff. (personal archives, 1983-4). Certainly staff experienced significant cognitive dissonance as they saw their patients, colleagues and infrastructure slowly slipping away: the level of denial was such that the Unit General Manager in PROV1 was heard to observe: 'They're not going to believe this hospital will close until they see the bulldozers coming up the drive'. (personal archives 1983) The hospital closed two years later. In PROV2 similar problems emerged with the staff 'left behind' as noted by the chief executive again: 'We had great difficulty in back filling posts in hospitals.' Although the Meso level in DHA2 considered that the support of general practitioners was crucial, it is surprising how many professional bodies and entrenched officials (as well as disaffected staff) were seen as expendable. In fact, in PROV1 and PROV2, there was an element of 'group-think' culture (Janis, 1972) which assumed any suggestions for slowing things down or stopping things happening from these alienated groups were not worth considering. This strong personal antagonism and personalisation of goals on both sides is compelling evidence of significant individual interest. The 'us and them culture' that permeated the service resulted in a certain amount of game playing and denigrating the opposition. The policy makers and implementers who drove the change were convinced of the rightness of 'the new cause'. They were also charismatic, relatively young and willing to take risks. (Personal archives, 1983, 1987).

Overall then, the 'losers' have included any individual or organisation who is against community care, and the 'gainers' have been individuals and groups who have associated themselves with the care in the community programme and sought to forward its benefits. This has cut across normal professional and political boundaries and forged distinctive and new alliances between doctors, psychologists, nurses, social workers and managers. What this tells us about mental health policy formulation in the context of interests is that it has been ideologically driven, whether at the Macro, Meso or Micro levels. This process

of policy formulation has not been an objective debate about the intrinsic merits of community care, but an ideological commitment at the highest and the lowest levels of the hierarchy to replacing the old institutions with more 'normal' settings within which to provide mental health services. Nothing less would do, no compromise was acceptable, no alternatives (as we noted earlier in Section 6.1.1) were to be considered.

6.4.5 Values and selective interests

Values form the normative ingredient of policy (Levin, 1997). Whilst the care in the community policy embodies a whole raft of normative judgements, the individual value judgements of actors involved in policy formulation as well as implementation also bear consideration. When interviewed, individuals at the Macro, Meso and Micro level, had strong views on the impact of values in the decision making process. They all agreed it formed an integral part of their work and had a significant influence on their practice although one Macro manager thought it was more about process than content, and that the civil servants were less affected by this: 'Yes – a manager's values definitely affect the decision making process. But more about *how* things should be done, that what should be done. Perhaps less so with civil servants.' (DoH.interview1, 14th March 1996). But the Macro level civil servant disagreed: 'Yeees. Most activity runs within a values band. There are tensions, and civil servants *are* affected by this variable.' (DoH.interview2, 14th March 1996). The lead officer for Trent region considered that there was a disparity of values between the centre and the DHAs, but did not really discuss the issue of values affecting policy making: 'Mental health is probably top of the policy agenda of the current government... but this is not always reflected by the chief executives of DHAs, despite the national pressures.' (RHA.interview, 1st November 1997). Meanwhile, at the DHA level, one planner in DHA2 felt that policy was shaped by values and expressed approval of a particular approach centrally: 'Yes. I'm convinced policy is underwritten by values. At least the values of people at the centre are spot on.' (DHA2 interview, 30th June 2001). Another DHA planner in DHA3 considered that the values at the Meso level affected policy: 'There is a dilemma. Policy-making is led from

the centre but at another level it is shaped enormously by local values, personalities, style and pragmatism.' (DHA3.interview, 4th June 1997). A further planner in DHA4 had even stronger views about values and policy making: 'Yes, (it affects the decision making process) probably more than anything else' (DHA4.interview, 26th June 1998).

The range of views was very similar at the Micro level, but what is distinctive at this level is the inherent assumption of the chief executive's own responsibility in this respect, as exemplified by the following four responses to the question 'Do you think individual values affect policy making?':

> 'Completely. People who are leaders are culture carriers. What they think and how they behave has an impact. Yes. It goes with the territory.' (PROV3.interview, 19th August 1999)

> 'Yes – without a shadow of a doubt.' (PROV1.interview, 3rd November 2000)

> 'Yes I'm sure they do. It's very difficult to be sure how though. It's not always apparent – certainly affected my operation without a doubt. If we didn't jointly believe in what we were doing we would not have been as successful.' (PROV2.interview, .3rd July, 2001)

> 'Yes, very much so. It's one of the strongest drivers. The mindset and values of the top managers are absolutely critical.' (PROV4. Interview, 17th September, 2001)

The above statements however hide as much as they reveal. The responses do not tell us what individuals' values actually are (or are professed to be). They do not tell us how they integrate their personal values with policy making, and they do not tell us what happens to their values when they are under pressure to make difficult choices, or to choose between competing interest groups.

So, having established that all these planners and managers across four districts and at the Department of Health considered that values did affect the decision making process, the next question to ask was *how* actors made decisions about resources, what was their concept of 'equality', not just in principle but in specific cases where they often had to make choices between competing groups. A qualitative survey was selected, called 'Resource Allocation Preferences Survey' (RAPS) developed by Fisher (1999). The survey was an instrument designed to identify individuals' personal values about the ways in which public services (in this case mental health services) should be allocated. There are two important features to note about this particular survey design.

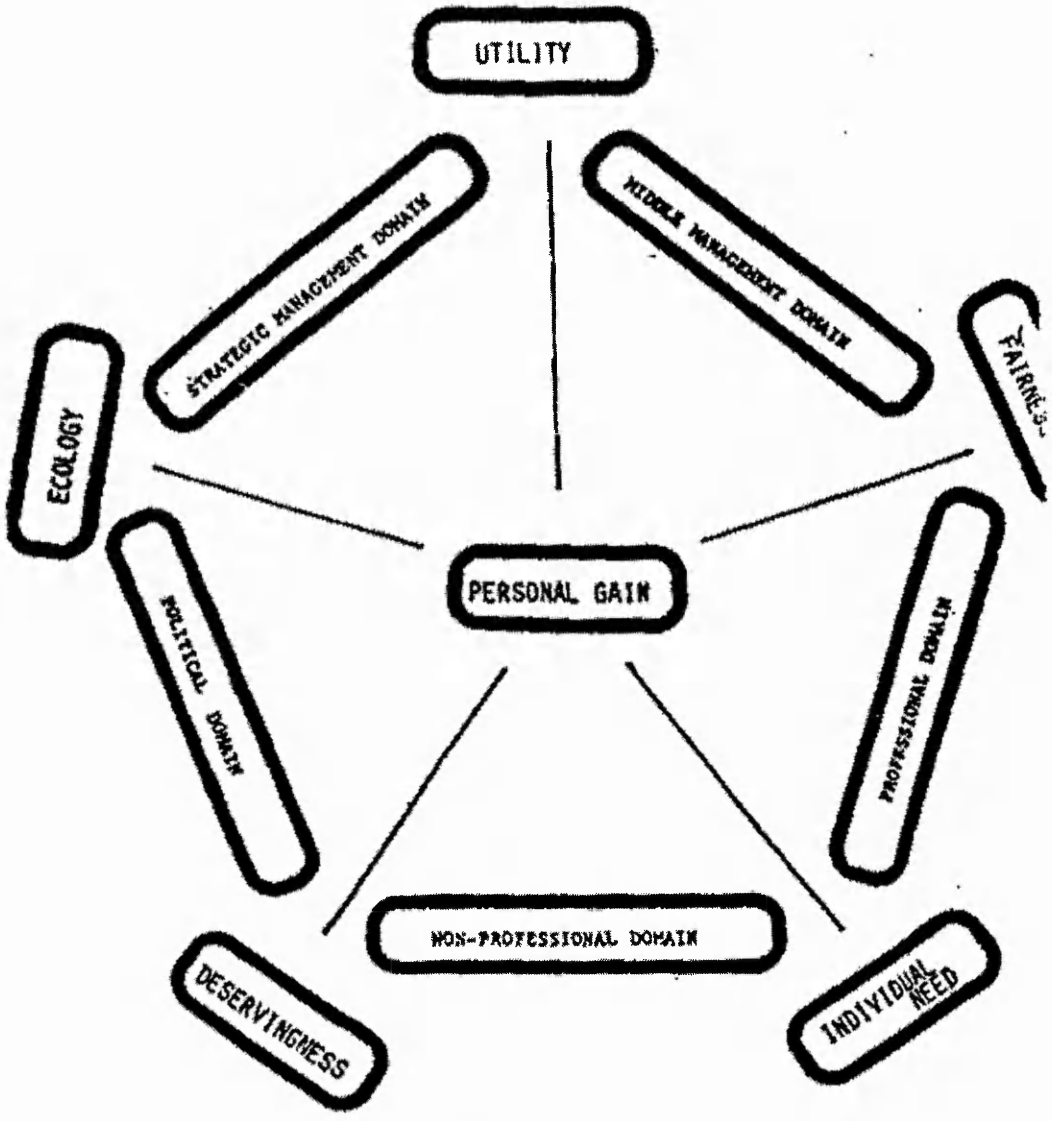
The first is that five different types of equity were identified: deserving-ness, individual need, fairness, utility and ecology. The *Deserving-ness* model divides resources between groups and individuals according to the resource provider's classification of them as deserving or un-deserving. This is a moral judgement. Groups or individuals who are thought to have created their own problems or to be too demanding are often labelled un-deserving. The *Individual Need* model responds to individual needs. It is not too concerned with the overview of the service but with meeting the needs of individuals. Needs are identified and ranked in importance by using professional judgement. It does not make moral judgements about individuals. The *Fairness* model is more concerned with treating all clients fairly than with the provision of services to individuals. Fairness is about standardisation and equal access to services by all clients. Its aim is to avoid accusations of unfairness, and can be planned or created by arbitrary means (such as queues in which all have equal probability of receiving services irrespective of their background or situation.) The *Utility* model is concerned with maximisation of output, that is to say with efficiency and effectiveness. It deals with the notion of the common good rather than individual need. Generating the greatest amount of good is more important than the way it is distributed amongst the community. The *Ecology* model allocates resources by taking

into account the demands of the various interests groups involved with the service. The greatest weight will be given to the most powerful or significant groups. The success of the allocation is measured by the extent to which it meets the needs of these groups; not according to objective or professional criteria.

The second important feature to the design of the survey was that there were two types of questions: one type focused on individuals' *espoused* preferences: for example 'resource allocation should involve measurement of output and the economic evaluation of professional activities and services'. The other type of question focused on individuals' '*hard case'* preferences: for example ' If budget cuts have to be made, then those departments and services which make the least contribution to the organisation's objectives should bear the brunt of the cuts'. Both these statements fall into the 'utility' model, but the second example is much more specific.

The findings of the original survey suggested that public service actors in different roles tended to occupy different pairs of preferences. Politicians tended to espouse 'deserving-ness' but in hard cases choose 'ecology'. Non professionals and the public tended to espouse 'individual need', but in hard cases chose 'deserving-ness'. Professionals tended to espouse 'individual need' but in hard cases chose 'fairness'. Middle managers tended to espouse 'fairness' but in hard cases chose 'utility'. Senior managers tended to espouse 'utility' but in hard cases chose 'ecology'. This is diagrammatically portrayed overleaf.

THE VALUE HEURISTICS OF
RESOURCE ALLOCATION



Mark the heuristics that you responded to.

The survey was adapted to make it more mental health specific, (Appendix D) and then piloted with approximately forty staff (two groups of clinicians and managers at the Micro level.) What was discovered from the results of this pilot survey was that the junior clinicians *espoused* a preference for the 'individual need' model, but when pressed (in *hard cases*) veered more towards a 'fairness' model. Clinicians who had moved into management positions *espoused* a preference for the 'utilitarian' model, but in *hard cases* veered towards an 'ecology' model. This pattern was established in just over 75% of cases. I then proceeded to survey my eighteen respondents who had formed the basis for my original interviews. The responses that I received were surprising to say the least. Sixteen out of the eighteen managers, planners, civil servants and pressure group leaders *espoused* a preference for the 'individual need' model. The same sixteen respondents all veered towards an 'ecology' model in *hard cases*. The other two respondents had a 'deserving-ness/ utility' range and an individual need/ utility range. What this suggests is that the actors in the mental health policy community, at different levels of the hierarchy and in different outsider groups hold more similar values (and tensions between *espoused* and *hard case* values) than might at first be supposed. This is one of the few areas where it is possible to suggest that there is convergence across all these different systems and branches of the organisation. The actors nearly always felt that the needs of the individual should come first. They nearly all accepted that, in practice, pressure groups and certain interests need to be taken into account when making mental health policy. The implications of these findings in terms of policy formulation is that actors experience an inherent tension between the needs of the individual and the political pressures of various interest groups. They all stress that values do shape the policy process, and so we must conclude that most policy choices in mental health are going to be made with significant consideration of pressure groups and interest groups.

However, this conclusion brings us to a real contradiction. When we examine the gainers and losers in the care in the community policy context, it cuts

across many of these interest groups. So how do managers and planners 'square the circle': that is take into account interest groups, whilst forwarding a policy that is broadly driven by ideology? Some clues arise when we pay attention to the interactions between managers/ planners and the pressure groups concerned. In DHA3 we have noted evidence that forums are created for user and pressure groups, but that the DHA 'goes ahead with what we had originally planned'. (Interview1.DHA3.) If we note the media pressure at a national level when pressure groups express concern, again there are conciliatory words but 'no change in policy' according to a chief executive in PROV3. It is entirely reasonable to surmise that whilst officials and managers' values do drift towards the 'ecology' model in hard cases, they take great care to protect the prevailing ideology of care in the community, which gives meaning and shape to their working lives. This has been put very simply and unarguably by the DHA2 planner: 'At least the values of people at the centre are spot on ...keeping people in their own homes wherever possible.' (DHA2.interview, 30th June 2001). This finding does however suggest some cognitive dissonance between what actors feel they ought to do in policy terms and what they actually choose to do 'for the greater good.' It is still a puzzling contradiction, that has not been completely satisfactorily explained by my research to date.

Summary to Section 6.4

Whilst we have been able to identify many factors which suggest that mental health policy formulation at the Macro, Meso and Micro level has indeed been a selective response to individual interests, how these interests are shaped and become entrenched needs further exploration. The next section deals with this view of policy formulation as a reflection of organisational culture. This model cuts across the three hierarchical levels of the organisation, and so I have considered this analysis of policy and culture as a whole.

6.5 Policies and measures as a reflection of organisational culture

If we wish to assess how structure and culture have affected the policy formulation process, we need to consider the formal long term structures within the Department of Health and other agencies, as well as any temporary structures. The *gaps* between sections and organisations are just as important as the *links* in this respect. To examine the underlying culture we also need to consider how people relate to each other in organisations, the history of the organisations themselves: the *'way we do things round here'* (Bower, 1966). This will include examination of the formal nature of the organisations, how many rules and regulations exist, the importance of job descriptions and hierarchy, how specialised departments are, how people get promoted, and whether posts tend to be permanent or not. But this analysis is not simply a diagnosis of the prevailing structure and culture but an enquiry into how individuals, particularly managers, are shaped by this structure and culture, and how they in turn shape their organisation to gain influence or access into the policy formulation process.

6.5.1 Cleavages

Much of the analysis of organisational structure and culture focuses on the linkages or routes between different people, departments and agencies. What can be just as important when considering such structures in policy making are the dis-junctions or cleavages (Levin, 1997) between individuals and groups. The important cleavages in mental health policy and structure at a Macro level are those between the Department of Health and the DSS (formally separated in 1983) and that between Ministers and officials. Recent initiatives which have bridged some of these gaps include the establishment of the Social Exclusion Unit in the Cabinet Office, the publication of the discussion document Partnership in Action, and the issuing of the first joint priorities guidance to Health and Social Services (with mental health established as a national priority.) The establishment of Health Action Zones, whilst a national

initiative, will have more of an impact on the gaps at the Meso and Micro levels, as will the introduction of Health Improvement Programmes. However there are still some significant cleavages between Health and Social Services: inspection and enforcement procedures are still separate, with varying responsibilities shared between the Social Services Inspectorate and the Mental Health Act Commission although since 2000, SS inspectors are seconded onto DHA inspection teams, and NHS staff have joined SSI teams. There is no political consensus on the issue of integration and we have already noted the mechanisms by which civil servants successfully deflected the attempts of John Major's Government to bring together the two agencies. (See Chapter Five, Section 9.) There are arguments against such integration, including workloads and creating new boundaries with other key agencies such as housing but the Commons Health Committee has come out in favour of closer ties: 'We consider that the problem of collaboration between health and social services will not be properly resolved until there is an integrated health and social care system, whether this is within the NHS, within local government or within some new, separate organisation.' (1999, HC74-1). There is therefore the political will for this to be implemented but that this integration is unlikely to materialise tells us much about the vested interest in the *status quo*, in both agencies as well as the difference between a political and an administrative imperative. There are also important gaps within the Department of Health which are less visible. Since the abolition of the regional health authorities in the early 1990s, the integration of NHS officers into the Macro level has been uneasy, according to a Meso level planner in DHA2: 'The officers are not viewed as 'proper' civil servants, they are viewed with suspicion.' This internal conflict can create its own problems, not least because the level below (Meso) have picked up these inconsistencies and with them a lack of clarity: 'It still feels like another layer.' (DHA2.interview, 30th June 2001). Further down the hierarchy, there are quite different tensions.

A key constraint on co-operation between health and social services at the Meso level is that of accountability. Local authorities are accountable to local

politicians, whereas local health managers at the Micro/ Meso levels are accountable to the centre. So directives from the NHS such as the Health Improvement Programme (HIP), whilst intended to address both local and national needs may not fit with local politicians' views of their community needs. The risk is that the HIP might be perceived purely as a health plan, leaving other players to develop their own strategies and targets. A further tension between health and local authority lies between the local authority policy of 'Best Value' where services can be delivered from a range of suppliers and the introduction of clinical governance in the NHS. The latter lays a statutory duty on health chief executives to ensure that a quality service is provided. How can the agencies keep control of services without running them themselves? And is it fair to expect small voluntary agencies to introduce the same expensive and complex mechanisms for quality control that a large hospital might need? The Partnership in Action discussion paper (Department of Health, 1998) which proposes a 'lead commissioner' arrangement may drive agencies towards merger at a local level. Certainly as Primary Care Groups and Primary Care Trusts mature, the likelihood of merger grows. Below the Meso level, the establishment of Primary Care Groups led by GPs next year will replace most commissioning work currently carried out by DHAs. Mental health assessment work is in its infancy at this level and there is little evidence of user involvement so this new and crucial groups of planners demonstrate yet another cleavage between health users and the professionals that are supposed to serve them. It is possible however, that these more local commissioning groups will eventually be able to represent their local population more appropriately in the longer term, but in the meantime there are significant risks of added isolation and pressure on GPs to deliver ambitious objectives. A further gap lies between the professional groups themselves. Their inability to share information (even between hospitals and general practices) creates unnecessary delays and can even lead to inappropriate treatment. (Gardiner, 1999)

The above analysis demonstrates just a few of the structural difficulties inherent within health, and between health and social services, when it comes to formulating joint policies. The mental health service does have a long history of joint working, but the evidence suggests that the Macro level is particularly important when it comes to working together. We have noted in Chapter Five that the quality of management at the Macro level is perhaps less important than the Meso level in policy initiation and when a particular policy is formulated for the first time. However, when we observe the structural cleavages between the organisations concerned and how this affects the policy formulation process, the confused and mixed messages that emerge from the centre and the new cleavages that are appearing at the Micro level all point to more rather than less distance emerging between key groups and agencies.

6.5.2 Linkages

Moving on from our general analysis of structure and gaps between the organisations, we can now consider what the linkages are between different parts of the organisations concerned. These can include informal as well as formal communication channels internally, between individuals. At the Macro level, tracking how individuals communicate can be followed in a number of ways. The two senior mental health managers in the Department of Health were asked to rate a series of statements on decision making (from (a) I strongly agree to (e) I strongly disagree. (See Appendix B for full questionnaire). Four of these statements referred to communication issues, namely:

* *Your boss consults you on all decisions* (both answered 'I strongly agree')
* *You feel like a cog in a large machine* (one answered 'in general I agree with this', the other answered 'In general terms I disagree with this'.)
* *Decision-making in your organisation is made by a few cronies behind closed doors* (both answered 'in general I disagree with this.')
* *Written communications are a very important part of the organisation* (Both answered 'I strongly agree.')

(Q.Macro.5.96)

Whilst there are many overlaps on other policy issues inherent in these statements, what we can note from the above responses in the context of *communication* is that at the top of the organisation, officers felt they were consulted by their leaders, and that most important decisions were made in an open manner. There is a difference in the way the two respondents considered their role in the organisation; the most senior respondent (with an NHS nursing background) did NOT feel like a cog in a large machine, the second in command with a civil service background DID feel like a cog in a large machine. It is reasonable to assume that the career civil servant saw his organisation as the whole of a very large civil service, whilst the ex-clinician saw his organisation as a separate health branch (ie the Department of Health). Both officers considered that written communication was very important in their organisation, often at the expense of oral communication. However, when we examine discussion in meetings, many of the oral comments shaped discussions and agendas, perhaps more than officers realised. (see Chapter Five, Section Nine.)

A further analysis was carried out, examining the inbound email traffic for the Lead Officer (Mental Health) at the Department of Health over a one week period. The period chosen was from 29th April until 3rd May 1996. The Lead Officer received 160 emails, eight of which were from the Minister's office, two from the Regional outposts, and the remaining 150 were internal to the

Executive. The subject areas covered were considerable and included news and advice on crises, such as missing 'at risk' patients, untoward incidents and deaths of patients. These constituted approximately twenty emails. The remainder covered issues from the mundane (such as car parking) to the routine (Priorities and planning guidelines.) Whilst it was not possible to read the contents of the emails, due to their confidential nature, it is possible to assess the weighting of different issues that occur over a period of time. Although the majority of emails were routine in nature, there were a significant number of crisis emails (approximately twelve percent) that needed urgent attention. A large majority of emails were internal to the Executive, and this demonstrates the high level of written rather than oral communication that exists at this Macro level. To summarise, Macro officers consider that they have good communication links between themselves, although the links between different agencies are less effective. This is borne out by the almost non existent electronic communication between the Executive and other agencies. The ramifications of this for policy formulation, particularly when we include consideration of the limited access that pressure groups have to Ministers and officers (explored in Chapter Five), are that civil servants are still operating in a relatively 'closed' network on a day to day basis.

At the Meso level, inter-departmental working parties, official documents, machinery for monitoring and co-ordination and the overall structures of the organisation are all examples of formal communication. At the Micro level, organisational charts, multidisciplinary teams, committee structures and circulation/ distribution lists from meetings indicate formal communication channels. However, informal communication channels also exist which are just as important. In fact because so much communication takes place behind the scenes in the policy making process (Harrison, Hunter and Pollitt, 1990: 15) we have to look for behavioural clues which can be observed in meetings and by studying individuals' conversations. We need to chart who talks to whom, and also to consider whether there are any gatekeepers who can speed up or delay

access. This was carried out through conversational analysis of interviews as follows.

The access between the Micro and the Macro level appears to be limited, as Macro officers stated that they rarely get involved with this level 'unless there is a crisis' (RHA1.interview, November 1997) and Micro level chief executives stated that they hardly have any communication at all with the national level, as noted by PROV2: 'I have almost no dealings with the RHA at all.' (PROV2.interview, 3rd July 2001). But further enquiry revealed that there were a number of crises, financial and involving patient care where the Macro level did interact with the Meso level. The other area where these two levels interacted was not identified by the Macro or the Micro level, but by the Meso level in DHA2. The issue was about contracting and this went to the Region for arbitration, as noted by the DHA2 Meso planner: 'Whenever they (providers) went to arbitration about contracting issues, the Region ruled in favour of the Trusts.' (DHA2.interview, 30th June 2001). This was not an isolated incident and it is clear that there is more communication between these two levels than might be expected on the initial evidence. The significance of this communication is two fold. The first type of communication tends to be crisis driven and nearly always results in bad blood, as we see from the PROV2 chief executive's comments: 'Region behaved like pigs. Concerned only to save their own skin.' The second type of communication results from a breakdown of agreement between the Meso and Micro level in contracting arrangements. The evidence that the Macro level '*nearly always*' rules in favour of the Micro level results in negative experiences between the Meso and Macro level but also affects the future relationships between the Micro and Meso level locally. The Micro level have learned that they can always appeal (usually successfully) to the Macro level, and will be more likely to appeal in future, weakening the Meso position still further, as noted by the DHA2 planner: 'In practice it never felt that the NHS Trusts were subservient to the DHAs. They always held the real cards.' The gate-keeping role of the Meso level is also quite significant. Whilst all the

evidence in the 'early mover' unit (DHA1) points to the Meso level protecting and supporting the Micro level in its efforts to put policy into action, the evidence for the later mover (DHA2) is quite different. The PROV2 chief executive commented that: 'Some of the DHA members walked around K hospital whilst I was on annual leave' and because they did not approve of the standard of services that they saw, he 'was summoned to account' on his return from holiday. Arranging inspection tours when the chief executive is on annual leave does not appear to be the best way to ensure collaborative working between the two levels! Most of the battles tended to be about resources and we have already noted his concerns that as money was saved from retracting one hospital, the money was being used to fund other parts of the health service: 'As beds closed and services retracted, the DHA kept the money and I believe this went into the acute units.' Overall, the provider's perspective of the Meso level in DHA2 does not suggest he had much support, though it does point up the important gate-keeping role of the Meso level: 'After much argument I went down to the RHA with the DHA and my Nursing Officer and argued very strongly for capital money and got 5 million pounds which provided replacement hospital services in the DGH for the elderly and acute mentally ill. I'm absolutely certain that the DHA were *lousy advocates*.' (PROV2.interview, 3rd July 2001) The chief executive's view was that until he visited the RHA to put his case, the needs of the mental health unit were being suppressed by the 'gate-keeping' Meso level.

We can conclude from the above analysis on linkages that there are contingent links between the Macro and Micro level, which tend to get used in the event of a crisis or a dispute and that this colours relationships between and among the three levels. The Meso level frequently gets 'caught in the middle' and is perceived as a 'gatekeeper' by the Micro level. The linkages affect the policy formulation process in a number of ways. It allows the Micro level to 'express its views' as well as acting as a safety net in controlling the Meso level of power. The Macro linkages also shape the policy formulation debate through a wide range of stakeholders including other agencies and user groups.

6.5.3 Dependency and how managers play the game

A rather more nebulous form of linkage has been defined by Levin, (1997: 58): that of *dependency* between individuals or groups. This type of linkage could arise from a number of mechanisms, such as financial arrangements, political support, statutory duties or contractual requirements. Some of the deliberate mechanisms to ensure dependency have been set up by the organisations concerned to foster closer working, for example the introduction of the Mental Illness Specific Grant in 1989 by the Department Of Health, with new capital monies which could only be accessed on the production of agreed plans between health and social services. Other more recent examples include the establishment of the Independent Reference Group to advise on hospital closures in 1998 and the setting up of the External Reference Group to steer the development of the National Service Framework for mental health services. Representatives on both bodies include professionals and users. The latest, 1998, NHS Information Strategy was also an attempt to improve the way information is shared between agencies, but is not effective yet. At the Meso level, recent evidence (Department of Health, 1998) suggests that only 42% of health and local authorities have integrated recording systems, and there are still some real difficulties for social services staff accessing health related data. However, setting up mechanisms for dependency at a Macro level can be very effective providing that there are specific incentives.

There are also less formal dependency links which will have emerged for quite different reasons, for example professional or managerial loyalties, sympathy or altruism, which also tell us more about the underlying culture of the organisations concerned. One particular dependency link which emerges in managers' discourse is that of managers shaping their organisation and how the organisation shapes them as noted by a provider chief executive: 'People make the difference but the organisation shapes them – gives them parameters.' (PROV2.interview, 3rd July 2001). This view is echoed by an ex social services senior manager as well: 'Individuals are more important than roles.

Being unorthodox and willing to take risks ... networking and working through other people ... are what the job is all about.' (Social services interview, 14th September 2001). This emphasis on individual contribution is borne out by the views of the Chief Executive in PROV4. With the advent of the modernisation programme (Department of Health, 1998a) and a new chief executive, the search was on for effective and innovative people to lead the changes. The Chief Executive stated:

> You can have all the policies in the world, but unless you've got the right people, you can't move ahead. We are playing a bigger game now, and if things don't work out between health and social services, you can't just take your ball home. We have been through some rough waters, but have made it work. It's not an overnight process; it's a big culture change.
>
> (PROV4. Interview, 17th September, 2001)

This has been a recurring theme at all levels of the NHS organisation and although it has not always been expressed in the same words in each case, the theme is very much that of individuals and institutions – or how managers play the game. Managers at all levels of the organisation have been involved in policy formulation to some degree but while we have considered their involvement as a rational (or not) process and as a response to individual interests and values, if we are now examining policy formulation as a reflection of culture, we need to consider the way in which their roles as *managers* affect this process. The interaction between managers and the institutions in which they work can be complex: if institutions are made by individuals, institutions can also constrain these individuals' actions through both formal and informal rules, norms and behaviour. (Lowndes, 1996). There are many schools of thought in institutional theory and whilst some focus on the ways in which institutions are formed by rational actors pursuing their interests, others explore the social processes through which shared understandings are shaped and conventions formed (Clarke & Newman, 1997: 86). It is this school of social process and the approach to institutionalism that we will be examining in mental health policy formulation, in the context of culture.

There are significant differences between the Macro, Meso and Micro levels in this respect. At the Macro level, officers consider that their organisation has a high degree of formalisation: with formal rules, job descriptions, and written communication being particularly important. There is a clear hierarchy as an organisational form, with very structured criteria for appointments and most appointments being permanent. (Rating Q.Macro.5.96). At the Meso level, there is a chronological shift, though once again, job descriptions, written communication and clear criteria for promotion are all noted to be typical of their organisation. The changes have centred around 'rules' which were seen as circumvented in the past, but there is less discretion now, and in functions – staff have more flexible roles and functions than in the past and were expected to rotate and more recently work in quite different locations and with different agencies. (Q.Meso3.1987). At the Micro level, we probably see the most informal and fluid structures. Rules and job descriptions were seen as 'window dressing' (personal archives, 1989) whilst oral communications were particularly important. Staff were expected to perform in flexible and changing jobs whilst the criteria for promotion was often weighed on skills-shortage criteria or the risk of losing key players. One manager in PROV2 who had applied for a post in another district was 'up graded' on the evening following her interview and job offer. (Personal archives,1989.) Overall then, the structure and underlying culture at the different levels is quite distinct, with the most freedom and least formality lying furthest from the centre.

But managers locally have also *re-cast* many of the assumptions about managerialism and its perceived values. The general changes to national policy making over the last twenty years and the 'centrality of managerialism' (Clarke & Newman, 1997: 104) to that process has had a significant effect on policy making in mental health services. The tensions between managers and professionals may not have been so overt as in other public services, but this is more to do with the relative lack of power enjoyed historically by mental health professionals, as noted in Chapter Two. However managers have taken the central values of managerialism such as efficiency and professionalism but

added their own priorities of public accountability and user voice (Lowndes et al 1996). This is illustrated by Meso planners: 'Relationships have changed fundamentally. Now we link strategy with commissioning. Evidence of activity used to be based on 'Finished Consultant Episodes', as if that meant anything! We're much more qualitative now with user involvement and monitoring.' (DHA2.interview, 30th June 2001) Although the Macro level might argue that they considered user involvement a high priority, when we examine how they allocate resources, a different picture emerges, as noted by the DHA2 planner: 'There's a lot of rhetoric from the national level on user involvement and we want to steam ahead but again it's not a national priority financially.' (DHA2.interview, 30th June 2001). Overall, then, when we consider how managers shape institutions and institutions shape managers, it seems fair to conclude that at the Macro level, the institutions have far more influence on individuals, whilst at the Meso and Micro levels, managers have infused managerialism with other quite distinct values and re-shaped their institutions as a result. There appears to be an invisible ceiling beyond which individuals struggle to shape their organisation and this is located at the Meso level. At the Micro and Meso levels, there is evidence that managers and professionals can have a significant cultural effect on their teams and their units. The Chief Executive in PROV4 noted that: 'managers need to have strong personal values about standards and ethics, to shape changes and to lead the way.' (PROV4, Interview, 17th September, 2001.) However, at the Macro level, the *discourse* of civil servants as well as their response to questionnaires excludes any reference to this type of cultural autonomy. This is noted whether they are talking about individual values in policy making, in the discretion and choice they have or do not have in their work and in the extent to which they feel the organisation can be shaped by them. 'I feel like a cog in a large machine' (Macro.Q2.7.96). If Macro level individuals are shaping their organisation, they are doing so unknowingly. A compelling example of the influence ratio between the institution and the individual is found when we examine the case of the DHA1 District Administrator (the 'early mover'.) After the policy success he enjoyed at the Meso level in the early 1980s, he

was appointed to lead a national 'mental health task force' to 'ensure that the radical changes the Government wished to impose on mental health services would be promoted and sustained.' (Ramon, 1997: 19). Whilst there were a number of successes such as the initiation of ten user conferences nation wide, a monthly newsletter, the provision of approximately 100 small grants for innovative projects and an emergency assessment of mental health services in London the task force was disbanded after two years and it is difficult to evaluate the long term effects of this initiative. However, when asking chief executives in interviews where they think they can have the most impact, as managers, not one cited the possibility of being able to make a significant difference at the national level.

Conclusions

There is overwhelming evidence that the Macro level has been involved *in policy formulation as a selective response to interests*, and that this is partly a reflection of the power structures within which the organisations are located. However, this has been supported by an extremely strong ideological framework. Policy making as the *product of a rationale* is notable by its absence. Significant gaps between agencies and departments have created cleavages within mental health services at all levels of the organisation and this process is continuing. There are some new links between different agencies for planning and delivering services, with evidence of user involvement now at the highest level. However, the linkages are structurally weak and tend to change with new governments and new policies – they are only as good as the individuals who hold the constituent parts together. The effect of individuals on policy formulation is interesting, in that the individual appears to have more cultural autonomy at the Micro and Meso levels of the organisation that at the Macro level. This may be partly because of the political influences at the Macro level, but also may be a product of the distance that Macro officers are from the 'sharp end'. Mental health policy has also been formulated at the Meso level, and this process, whilst mediated by the Macro and the Micro levels, has,

historically at least, been conducted in a *relatively rational* manner. There have clearly been considerations and interests that have affected the way policy has been formulated but their influence is not as significant as one might have expected. This state of affairs is however changing significantly, as the Macro level has become much more directive over the last three years. I have argued in Chapter Five that the Meso level adopts a very 'robust' approach to policy initiation and the evidence that we have considered in the current chapter confirms that this approach continues through the process of policy formulation, despite the pressure to include interest groups. Meso level planners and managers have become more sensitive to the needs of users and pressure groups but the general impression from their language, methods of working and actual policies denotes that they have a strong sense of their own expertise and mandate, that has until very recently been strengthened in the intervening years of this study. Significant mental health policy tended to be formulated at the Micro level in the early 1980s, although there is evidence that minor policy issues arrive and are responded to even now but this process tends to be quite reactive. There was a period between 1990 and 1995 when the Micro level exerted significant expert power to formulate policy in the early stages of the contracting process, before the Meso level 'caught up'. Just as the Meso level reached its zenith of knowledge, expertise and confidence in 1997, there was a change of government and policy formulation at this level was effectively extinguished.

CHAPTER SEVEN:
POLICY IMPLEMENTATION IN MENTAL HEALTH SERVICES

Introduction

In this chapter, I will be attempting two tasks. I will be examining how mental health policy has been implemented over the last twenty years in the UK. I will also be assessing how difficult it has been to implement mental health policy in the UK and what its chances were for success during this period. Whilst all the other stages of policy making occur at the Macro, Meso and Micro levels of the organisations concerned, policy implementation in the sense of policy delivery rests exclusively with the Micro level. The Micro level does not have much to do with the Macro level, unless there is a crisis (as noted in Chapter Six) but it interacts significantly with the Meso level and so the relationship between these two levels will also be considered in this process of policy implementation.

In Chapter Three we considered the growing interest in the study of implementation. There are many models of how policy might be implemented but they can broadly be summarised (in relation to mental health policy as follows. The first is the rational, top down approach, the second is the street level bottom up approach, the third the evolutionary approach and finally the political game approach. The top down approach emphasises the importance of minimising implementation deficit – in mental health policy making such a model suggests a complete policy formulated at the Macro level: policy is 'taken to be the property of policy makers at the top' (Ham & Hill, 1993: 101). In this type of model, all the issues to be tackled are based on reducing any potential implementation deficit, ensuring that policy is unambiguous, that there are as few links in the chain as possible, that there is minimum outside interference and that policy makers have control over implementing actors. In the preceding chapters, we have already noted the complexity and confusion surrounding mental health policy, the many links in the chain, the dependence on other agencies and the difficulty in controlling implementers, particularly professionals. The second approach is at the other end of the spectrum. In the

bottom up approach, implementers have the responsibility and choice about how and if they implement policy. A number of reasons are advanced for the benefits of such an approach including the need to be able to resolve conflict locally, to allow implementers who have all the facts to make the key decisions and the desirability of allowing professionals to use their discretion (Ham & Hill, 1993: 108-9). However, it is not just professionals who can be argued to be using their discretion; Lipsky (1980) suggests that lower level bureaucrats also strive to re-shape policy to bring order into their own working lives: 'I argue that the decisions of street level bureaucrats, the routines they establish and the devices they invent to cope with uncertainties and work pressures effectively become the public policies they carry out.' (1980:xii). These 'street level bureaucrats' are no necessarily occupied in advancing their public service ideals, but in developing strategies which help them to cope with their workload and the pressures in their jobs. The coping mechanism fits well with the use of negative power: to 'slow things down or stop things happening' (Handy, 1991:). In mental health services we might usefully ask whether there is a distinction between Lipsky's street level bureaucrat and the role of the mental health professional. Certainly the semi-professional role of social worker, occupational therapist or mental health nurse might be classified as a street level bureaucrat who could not be 'readily brought under the control of a supervisor' (Ham & Hill, 1993: 141.) The community mental health teams in the PROV2 were all managed at a distance by a manager who was usually drawn from one of the professionals, but who did not have the knowledge and expertise to closely supervise each member of the multi agency team. The individual team members tended to be self regulating, although from 1987-89 there was also a link between each member of a team and their professional supervisor, normally based at the hospital. Thus, the teams were managed by one individual and professionally led by up to four others. The appraisal scheme that resulted was three way, with a professional, a manager and the appraisee meeting to evaluate performance. (Personal archives, 1997-1999.) This system was slowly eroded as the teams became more numerous, developing in confidence and expertise, perhaps outgrowing their professional mentors. It is possible to argue that these professional fitted

the role of a street level bureaucrat by virtue of their semi-autonomy, their regular interactions with clients and the lack of hierarchical control over the pace and quality of their work. Work was divided up and regulated through case conferences, consisting of multi professional peers. Ham and Hill summarise this debate neatly: 'In this sense, professionals are street level bureaucrats who have been able to develop special claims to autonomy.' (1993: 148). In this chapter we shall be examining how the provider level does or does not exert control over their 'street level' staff and what mechanisms are used to control or shape behaviour. We have already noted that professionals protest that they do not have much discretion at all in their work and yet shape policy initiation significantly, through referral patterns, diagnosis and case work decisions.

If top down implementation is the opposite of bottom up, then it is fair to say that the third method of policy implementation that is to be considered lies somewhere in the middle. The evolutionary approach tends to occur when there is significant policy ambiguity, but factors such as the feasibility or otherwise of a policy are also considered. The approach is characterised by an incremental approach to policy implementation, whereby pilot schemes may be tried and adapted and then fully implemented. There is normally evidence of discussion between the different policy making levels, particularly the Meso and the Micro levels and some flexibility in how the final implemented policy might look.

Policy implementation as a political game could lie almost anywhere on the continuum that we have marked out. In this model we would expect to see bargaining and persuasion between the Meso and Micro levels: conflict and deal making would be the normal strategies used to get policy implemented. So this approach is contingent on a number of factors: the relative strengths and skills of the two levels would determine, in the end, how top down or bottom up the implementation method actually became.

In this Chapter, I will argue that the level of discretion in implementation of mental health policy, particularly that of community care, can be tracked on a chronological continuum. The early mover units of the 1980s adopted a *bottom up* approach, in the absence of any detailed policy, in what was essentially a policy vacuum. The later movers of the late 1980s had more direction and attention from the Macro level mediated through the Meso level, and the approach was much more akin to implementation as an *evolutionary* process. In the early 1990s, provider units adopted a different approach: negotiating and exerting various forms of power, testing the boundaries between 'politics and bureaucracy', seeing implementation as a *political game.* By the late 1990s, providers had considerably less discretion in how they ran their affairs, for a number of reasons. The implementation choices have therefore been more limited, and the approach could be described as *top down.* This variation in provider, or Micro, discretion when implementing policy runs parallel with their discretion when formulating policy. We have already noted in Chapter Three that many implementation models tend to conflate policy formulation with implementation. However, there are examples where policy that has been formulated at a Macro or Meso level has been changed through the process of implementation by the Micro level. This is quite distinct from the Micro level formulating and implementing policy in a *policy vacuum.* I will therefore be considering the factors that have changed the way that providers have been able to deliver and shape their services over the space of twenty years as they implement policy, attempting to distinguish between policy *changes* at the Micro level and a policy *vacuum* at the Micro level.

Attention will also be paid to the problems and pitfalls associated with implementing policy, from the Micro, managerial, perspective. We have already considered some of the potential *difficulties* associated with the process of implementation in Chapter Three, and in this Chapter Seven, the difficulties are considered in the context of four different providers across twenty years. The studies are broadly chronological, the first being the examination of an 'early mover' provider unit in the early 1980s (PROV1), the

second a later mover in the late 1980s but continuing the study until the year 2000 (PROV2), the third a provider unit grappling with the contract culture of the internal market in the mid 1990s, (PROV3) and the fourth the ongoing process of policy delivery into the new century under a new Labour Government (PROV4).

It is important when assessing relative difficulties or problems in the implementation process, to select a relevant framework, which takes into account the special circumstances of mental health policy. It is also useful to use a comprehensive framework that covers all possible factors. We are looking at four different providers over a period of twenty years, and issues which would not concern earlier managers might well emerge for later managers, and vice versa. The environment in which the different providers were working in is also important. Therefore, we need a framework that is relevant, comprehensive and contextual. Chase's framework (1979) which considers *operational* difficulties, *resource* difficulties and *sharing authority* difficulties is perhaps the most useful for a number of reasons. Other writers such as Gunn (1978), posit pre-conditions necessary for 'perfect implementation' which explain much about policy failures. However they do not tell us why some rather unlikely policies, such as community care in the 1980s, succeeded in certain units and not others. There is a growing literature on the creative potential of strategy makers to shape change, by writers such as Pettigrew et al (1992,) that consider cultural and political processes of organisational life. But many *barriers* to achieving change are also cited such as poor estate, professionals in conflict and lack of support or interest from above. However, one of the 'early mover' providers (PROV1) experienced all these barriers, and yet managed to utilise them as tools to promote change. (Personal archives, 1983.) Many approaches for assessing implementation difficulties are not specific to services that are directed at people. Mental health services are directed at vulnerable people, and Chase's framework is less a checklist for policy failure and more a map for predicting the difficulties that may lie ahead in particular cases. It is very much a contingency approach to assessing risk and problems, rather than forecasting, or justifying, failure.

The first strength is that it has been constructed to fit human service programmes rather than product based services. The second strength is that it focuses on the use of structured questions that helps to interrogate the data in a way that is both consistent and reproducible. The third strength is that it can compare similarities as well as highlighting differences. However it is by no means a perfect framework. It cannot take into account every single issue that might be relevant to managers. Using structured questions entails a degree of subjectivity. We may well find that one manager's difficulty is another manager's strength. But if a manager considers that (s)he had significant resource difficulties and another manager with the same allocation considers that resources were not an issue, these responses in themselves tell us more about the managers concerned, their skills and attitudes. And so the appropriate use of structured questions can yield important information that goes beyond the original surface question. Chase's framework was constructed in the late 1970s, and so it could not forecast the sweeping changes that affected public services in general and mental health services in particular. Changes such as managerialism and the proliferation of agencies responsible for delivering care were not necessarily planned for in this framework, and so it has been necessary to adapt some of the questions. A final weakness lies in the concept of *difficulty.* The absence of a difficulty is not necessarily the same as the presence of a strength. Focusing on difficulties (or their absence) may miss some important positive factors. It will therefore be important to consider specific examples of success in the light of strengths as well as problems or difficulties.

Having considered the relative difficulties to policy implementation in mental health services for different providers, I will then consider whether there is a relationship between the level of difficulty and method of implementation adopted. I will be concluding, perhaps not surprisingly, that implementation of policy has overall become much more complex *for managers* in the last twenty years. Every single difficulty cited has grown or developed over the last twenty years, and what is surprising is that any mental health policy can be implemented at all in the current climate. When we consider the

increasing role of the Meso level in policy initiation and formulation in the early 1990s, we should also not be surprised to see the Meso level getting involved in the implementation process throughout this period as well, albeit at arms length. This was done through the way it conducted its relationships with Micro level providers, with the Macro level (as the only agent between Micro and Macro) and the system of contractual relationships it set up with the Micro level providers, including voluntary and not for profit organisations. These sit rather uneasily between the Meso and Micro level, as we have already noted in Chapter Six, Section 3. However, we will also note some important changes to this Meso dominance, in the more recent political climate at the end of the 1990s.

It is reasonable to conclude that as implementation gets more difficult for providers, the Meso level tends to get more involved, in shaping relationships with other agencies, in deciding levels and patterns of services and mediating with the Macro level. But what we cannot infer is which came first – the Meso involvement or the difficulties. To dig a little deeper into this relationship we need to compare two very recent cases of providers. In the past, the main factor that determined the relationship between the Meso and the Micro level lay in the quality of management at the **Meso** level (see Chapter Five). When the early Meso level purchasers had some knowledge deficits, in the early 1990s, there was some evidence that the Micro level became more powerful in implementing policies of their choice, as noted by the PROV2 chief executive: 'Some people say that the DHA grew in power with the purchase- provider split. But knowledge was power. We used to go into contract negotiations and we won most of the time. It took them a very long time to catch up, there was very little discussion in those early years.' (PROV2.interview, 3td July 2001). But by the mid 1990s, the Meso level caught up and even overtook providers in terms of epidemiological skills and information. Once the Meso level had the knowledge it needed and a contractual relationship with providers, the balance of power shifted to the Meso level. More recently however, there is evidence the Macro level are sufficiently empowered, informed and willing to be much more prescriptive,

which will significantly affect the opportunities for discretion in implementation according to a DHA2 planner: 'Now it's SO prescriptive. Down to the number of staff needed in a crisis team. Would have been different in the early 1990s. There was a STEP change with the advent of the Labour Government. Lots of detail now, with funds attached to that detail.' (DHA2.interview, 30th June 2001) What has changed from the 'early mover' years is the way in which the policy debate is conducted. It has moved away from a *bottom up* approach where providers could 'get away with murder' (IHSM Conference interviews.June 1990). The mid 1990s approach was predicated on a bargaining system, where providers could change and re-shape policy by negotiating with the Meso level, by utilising local pressure groups and exploiting loopholes or gaps. The method in which policy got implemented would traditionally depend on the quality of management at the *Meso* level. If the Meso level had high calibre, well informed managers and clinicians, they would set the tone for that district and shape the culture (the 'way we do things round here', Bower 1966.) However, very astute managers at the provider level, who were not averse to negotiating and trading as well as utilising local pressure groups could still make a difference, though not as much as in the more distant past. At the end of the 1990s, the pendulum has swung the other way: there is now a formalised and very 'top down' approach from the Macro level, essentially *by-passing* the Meso level, which is prescriptive in the detail, as well as in principles and values. In other words, the Macro level is not only determining the policy formulation process, in terms of ends, but is also attempting to get involved in the implementation process in terms of means, by dictating *how* policy should be implemented. The evidence for the Macro level by-passing the Meso level is unarguable with the Department of Health's plans to abolish the Meso level, almost in its entirety, by 2002, leaving just 28 strategic health authorities situated between the local primary care teams and the Macro level (reported in *Health Services Management,* June 2001.)

The rest of this chapter is split into three sections. The first section describes various methods by which policy might be implemented, and we shall be

considering four different possibilities and applying them to our four case studies. The second section assesses the relative difficulties experienced in implementing policy in the four cases. The third section then considers the relationship (if any) between method of policy implementation adopted and difficulties encountered, taking into account the chronological differences in the four case studies. It also summarises the shift in relationships that have occurred between the Meso and the Micro levels over this time.

7.1 Methods of policy implementation and their relevance to mental health services.

CASE STUDY ONE: the 'early mover' of the early 1980s. (PROV1)

We have already noted in Chapter Six the significant level of discretion allowed in shaping policy in this provider unit. As one would expect, the unit also had discretion in implementing policy. The Meso level appointed the 'change champions' and let them get on with it. The analogy with Elmore's 'backward mapping' (1981: 1) is very strong. By beginning at the phase where the policy reaches its 'end point' (in this case with individual patients and their needs) policies were organised to meet those specific needs as noted by the chief executive of PROV1: 'We decided to cut our losses and go for community based services'. Success was defined in human or behavioural terms that created the 'occasion for a policy intervention' – the services were deemed to be so poor, that it seemed simpler to start again: 'We soon realised we would spend our whole bl** lives doing this, (trying to improve the services) and decided to cut our losses.' (PROV1.interview, 1st November 2000). Elmore's concern was with the way in which managers are forced to make choices between conflicting or interacting programmes, and he suggested that backward mapping could be used as a way of coming to terms with this conflict. If we wish to analyse *why* the top down approach occurred in the early 1980s, we have to consider the actors involved as well as the environment in which they worked. Sabatier (1986: 37) suggests that the presence or absence of a 'dominant piece of legislation structuring the

situation' would pre dispose actors towards or away from a bottom up approach. Whilst there is some debate possible about the dominance or otherwise of the community care legislation, this can be short cut when we note that other provider units across the UK were all subject to the same legislation, and did not adopt this bottom up approach, to the same extent (they all tended to implement government policy much later than this particular unit.) What this does suggest however is that other factors can propel organisations towards a bottom up approach. All the evidence in the way this provider unit initiated, formulated and implemented policy points towards one factor that makes this unit different. This was the unusually supportive role of the Meso level. The other factor that we have touched on before is random chance or luck. Unless there is a completely parallel process gong on across the UK in policy implementation terms, there will always be early movers, intermediate movers and late movers. The factors which place them in any sort of order may appear to be quite small and insignificant at the time – a supportive District General Manager, a new unit manager (with very little managerial experience) may have been enough to 'make a difference'. Before we leave this particular early mover study, it is worth linking the managerial factor to Dunleavy's work on the 'skewed' policy implementation process (1981). Although this process focused on the effect that professionals (particularly medical) can have on policy as they implement it, in this early mover case, it is the managers here who dominated policy changes, rather than the professionals. So when we consider Alford's analysis of structural interests (1972: 164) it is reasonable to conclude that the dominant interests which emerged in the 'early mover' case were the managers, who might previously been considered the 'challenging' group.

CASE STUDY TWO: the later mover of the late 1980s. (PROV2)

By the end of the 1980s, circumstances had changed. Hospitals that were still open, despite fledgling community services, were soaking up resources, staff and management time. The pressure for change came from the Macro level, but was directed through the Meso level, through the new management

Review process. The Micro level had much more direction and attention from the Meso level as a result. In this respect the 'institutional context' (Lewis and Flynn, 1978:) had changed. The Meso level wanted to see change, and in particular wanted to see the closure of a specific hospital. But they did not appear to have very strong views beyond this: as noted by the provider chief executive: 'No control at all from the DHA. Left to my own devices. They weren't interested in how we implemented unless there was a complaint'. (PROV2.interview, 3rd July, 2001). Policy implementation had become an evolutionary process. There were still some 'ambiguities about policies and uncertainty about their operationalisation' such as the process and timetable for decanting hospital wards and 'conflict arising from ... pressure groups activity' such as the hospital versus community staff, and social services versus NHS concerns. All these pressures meant that policy was implemented on the basis of *feasibility* rather than simply a rational top down approach. Patients were 'repatriated' to a variety of localities, sometimes on the basis of support available rather than on their origins. Staff relocation to different localities was often on the basis of availability rather than demand. Thus some localities had occupational therapists working in the mental health teams and others did not. The presence of social workers in the multi-disciplinary teams depended partly on the willingness of the Social Services deputy director to release staff from Social Services offices in other areas, as well as the staff willingness to relocate. (Personal archives, 1989).

CASE STUDY THREE. The internal market (PROV 2 and PROV3)

Relationships had changed again by the mid 1990s. The introduction of the contracting process, as well as exhortations to compete, then to 'collaborate', the use of the voluntary sector as a supporting mechanism (the carrot) as well as the private sector (as the stick) had changed the way the Meso and the Micro levels interacted. The Meso level were growing in knowledge and confidence over this period, and the Micro level had to work hard to keep up. Conflicts and deal making, rather than seen as dysfunctional, became part of normal public service life. Methods to bring about compliance (Dunsire,

1978:) were not in place yet and now the emphasis was on 'bargaining, persuasion and manoeuvring under conditions of uncertainty' (Bardach 1977:) as noted by a DHA2 planner: 'In practice it never felt that the NHS Trusts were subservient to the DHAs. They always held the real cards.' (DHA2, interview, 30th June, 2001). When we examine the language used by the PROV2 chief executive, this fits in well with a conflict and bargaining model looking back on the mid 1990s: 'I think we were quite slick really. One step ahead of the DHA'. ' (PROV2.Interview, 3rd July 2001). By 1999, the chief executive of PROV3 was signalling some changes to this approach, as he stated: 'All money is targeted, very little discretion there.' His concern with the emerging Macro level involvement was also evident as he discussed the effects of the Commission for Health Improvement which would 'make a huge impact on discretion. This new approach challenges professional choices.' (PROV3.interview, 19th August 1999) All the above evidence points to the policy implementation process in the mid 1990s as a political game but shifting to something quite different towards the end of that decade.

CASE STUDY FOUR. New Labour (PROV2 and PROV4)

By the late 1990s the relationship between PROV2 and the Macro level was very much a top down approach, mediated only slightly by the Meso level. Goals were very clear, resources targeted very carefully. The DHA2 planner commented: 'Previously there was emphasis on principles and values but the detail is new, drawn from both local good practice and national initiatives. Pattern of services, CPA huge targets. Distinctions between assertive outreach and crisis intervention.' (DHA2 interview. 30th June 2001). This was echoed by the PROV4 Chief Executive, who noted: 'I have less discretion than I've ever had before. There is a very prescriptive policy agenda, and a very top down command and control approach.' (PROV4.interview, 17th September, 2001.) Communication between the actors was both formalised and regular (Pressman and Wildavsky, 1973): 'By 1998 you could hardly move without the Region breathing down your neck. We had performance mgt from the RHA and monthly visits – interesting – in fact they were much more

autocratic and directive than the old DHA.' (PROV2 interview. 3rd July 2001). There was a unitary line of command, and norms were enforced through the contracting process, as well as the power to appoint key staff. Providers were surprisingly compliant (did what they were told) and there was a very formal process of communication through the performance management process (Hood 1976: 6). This process was mirrored in PROV3 as noted by the Chief Executive: 'A big emphasis on delivery including more follow up and monitoring.' (PROV3 interview.19th August 1999.)

Summary to 7.1

This shift, from bottom up to evolutionary, then from a political game to a top down approach has gradually restricted implementation possibilities for mental health service managers. The way in which policy has been implemented has changed because of a number of factors. The first factor is connected with the 'early mover' syndrome. Any provider that is carrying out policy as a 'first' appears to have almost total discretion in the way that this is done. They are implementing policy in a 'policy vacuum'. However, this does not mean that policy has not been formulated; it does mean that the provider level has been involved in all three stages of the policy process. They are inventing the way ahead, they do not have a map, and they are 'learning by doing' (Pettigrew et al, 1992: 151). The second factor is connected with organisational restructuring. The contract culture of the 1990s gradually shifted power from the Micro to the Meso level, and reduced the chances for discretion. Further restructuring and a change of government has relocated the power further up to the Macro level, possibly for the first time in mental health services. The changes on contract length and the chance to plan longer term give providers an impression of security but with many strings attached. The emphasis is very much on performance measurement and control through results, and there only appears to be room for manoeuvre 'at the margins' for Micro level providers. The Chief Executive of |PROV4 noted: 'The pendulum has swung the other way. We used to have almost total power as self governing trusts. There is now a compression between the

Department of Health and the providers. They monitor every activity in great detail.' (PROV4. Interview, 17th September, 2001.) Whilst this may appear to be a victory for top down planning, and the Macro level, it is important to point out that the mechanisms that the Government can use to ensure compliance will not necessarily result in the required changes. There is still some potential for the exercise of negative power, to slow things down, to stop things happening, as observed by the outgoing chief executive of PROV2: 'I've been gone 2 years now. K Hospital was supposed to have closed by now.' (PROV2.Interview 3rd July 2001) What this suggests is that a 'top down' approach may prevent managers from doing the 'wrong' things, but it will not necessarily compel them to do the 'right' things.

These changes in the way that policy has been implemented has been matched by changes in the difficulties which managers experience. The next section deals with this aspect of policy implementation and considers the types of difficulty experienced in four different provider units across twenty years.

7.2 Difficulties experienced in implementing policy

There are bound to be difficulties in the implementation phase of any programme in the real world. This section considers three areas of difficulty, namely operational difficulties, resource difficulties and sharing authority difficulties. Operational difficulties focus on the practical aspects of implementing services for users, and include information collection and knowledge challenges. The resource difficulties do not merely focus on funding and budgets (though they play an important part). They also include personnel and space / infrastructure problems. The 'sharing authority' difficulty is perhaps the area that has affected managers the most, more recently. It is probably the most complicated to measure. We can count the number of agencies involved in delivering services, but it is also important to consider their relative powers in implementing policy. It does not merely mean a consideration of the agencies involved in provision of services, but takes into account pressure groups locally and the role of the media as well.

These groups have been taken into account to a certain extent, when considering how policy gets initiated at a local Micro level (see Chapter Five) but we return to these groups to see how they interact at the implementation stage in this next section.

7.2.1 Difficulties arising from operational demands.

The four questions that can be usefully asked under this heading are based on the type of service that is to be provided. The issues are broadly epidemiological but also touch on perceptions about mental health and illness. If we first *consider who the people are to be served,* one might expect this question to be answered in the same way across the three mental health studies. However this is far from the case. In the 'early mover' (PROV1) the people to be served (or who were planned for) were essentially a static hospital population. There was no community population that needed integrating into the policy. The whole focus was on a single group of people in one hospital. In the later movers (PROV2) the people to be served was much more of a shifting picture. There were two hospitals, each with separate catchment areas, as well as embryonic community services with their own groups of clients with their own needs and demands. In the more recent groups (PROV3 and PROV4) the picture was different again. There was only a vestige of a hospital, but there were reasonably mature community services supporting large and complex groups of people, through a mixture of different agencies.

If we next consider the *nature of the service* that is to be delivered, once again, one might suppose that the policy of care in the community might mean broadly the same sort of service, irrespective of geography if not time. But there are significant differences between the nature of service that has been provided historically across these three units. There will obviously be differences because of changes in treatment, in legislation and in support available in the local community. But there is also evidence that the type of service provided had a lot more to do with personal preferences and values of

individuals who drove the process of implementation in the early movers. There is also significant evidence of a growing use of a range of agencies to provide varied and distinctive services to meet what might be perceived as the same need, over the middle years of community services. However, if we assess the service that is delivered at the turn of this century, there is a definite convergence of culture and nature as noted by a DHA2 planner: 'Now it's SO prescriptive. Down to the number of staff needed in a crisis team.' (DHA2.Interview, 30th June 2001). A real homogeneity has been achieved. Whether this is a good thing is another matter. In PROV1, in the early 1980s, the service was almost exclusively planned and delivered by the NHS. In PROV2, by the late 1980s, the service was still led by the NHS but Social Services and other agencies were more involved in the provision of a whole range of services. By PROV3 and PROV4 in the late 1990s, there is significant user involvement in planning and evaluating services, and a much wider use of different agencies in providing a more structured template of community mental health services. The Chief Executive of PROV4 noted: We have spent a lot of time and effort on getting users involved in planning services. They sit on senior appointment panels, including consultant appointments, they are involved in clinical governance committees, and in all service reviews.' (PROV4, interview, 17th September 2001).

If we now consider what *the potential distortions and irregularities are in the populations* concerned, we can note that in PROV1, the population was 'captured' in the hospital. However, the needs of these patients were very different from subsequent ones, as the problem of institutionalisation tended to mask other mental health illnesses. In PROV2, there were significant problems in coping with distortions and irregularities in the population because of the comparatively small localities that were planning services. In PROV3 the localities were considerably larger and thus numbers were more accurate. In PROV 4 the return to locality planning through local planning support teams led by GPs had again reduced the populations planned for.

When we assess whether or not the Programme (or policy) was *controllable* by the Micro level implementers, we need to consider whether performance can be measured and if any parts of the service were not controllable. The policy of care in the community is renowned for the lack of quality controls that are in place, partly because of the complexity and lack of agreement about success discussed in Chapter Two. The irony of performance measurement was that it was most frequently carried out in very small parts of the service. An example of this is in PROV2 where joint planning bids of 10 000 pounds were evaluated in great detail by the Joint Planning Group, whilst millions of pounds were recurrently spent with no evaluation whatsoever. (Personal archives, 1989.) Wider problems of measuring performance were summarised by DHA3 in 1997: 'There are at least five thousand different user views on any one subject –from hospital closure to lavatory bolts. There is no cultural consensus and it is very difficult to synthesise all these conflicting values.' (DHA3.interview,4th June 1997). This was echoed by a DHA2 planner in 2001: 'It is *so hard* to be objective, though, in mental health services' (DHA2.interview, 30th June 2001) She continued: 'We've implemented a fairly structured approach to user voice. They are trained to interview clients about issues like CPA, (Care Programme Approach) they act as action researchers.' However, there were difficulties in getting the support of the providers for this type of consumer involvement, as the DHA2 planner noted:

> They presented their findings and the reaction was 'interesting.' The chief executive of the Trust pointed out that he was paying for it and did not want to use the results. Service users found that very difficult. The findings *did* go to the Trust Board, and were responded to through an action plan. The DHA constantly referred to it, as good practice.
> (DHA2. Interview, 30th June 2001)

What we can say from the above analysis is that performance appears to be more controlled than it was, more resources are put aside for measurement and evaluation, and a real attempt is being made to get users involved in this process, but this is driven at the Meso level in our example. And it is the Meso level which is to be abolished in 2002. What we can also see, from the above analysis, is that all the operational difficulties cited have grown over the

intervening years. As community services have developed and become more dispersed, as users have got more involved in planning and measuring the quality of their care, the operational services have consequently become more complex to manage.

7.2.2 Difficulties arising from the nature and availability of the resources required to run the programme

The next four questions deal with issues about resources, but also touch on power and influence.

If we first consider *money, the limits on funds, and the prospects for more*, in the early 1980s there were far less restrictions on funds than later. As the PROV1 hospital closed down, funds were released into the new community services, and bridging money was made available from other units and the Region to help the programme get started. By the late 1980s in PROV2 bridging funds had dried up, used by the 'early movers' and there is also evidence, from the chief executive of this unit, that the DHA had diverted mental health funds into general health services as psychiatric beds closed. The DHA was forced to generate extra money from the sale of land and other assets, and money was loaned to the provider unit:

> As far as bridging goes, we got a dowry system, from the regional strategic reserve. The RHA held this and released per ward closure, but we had to pay it back within 12 months. Very little additional money to put into community health services; got that eventually from ward closures.'
>
> (Prov2.Interview, 3rd July 2001)

However, there a new, national fund was provided in 1989, known as the mental illness specific grant (MISG). This was a grant of approximately fifty thousand pounds made available to provider units on the understanding that the money would be jointly planned and spent by health and social services for community mental health services. This MISG demonstrates the government's preoccupation and concern about the previous lack of multi-

agency working at provider level. By the late 1990s, in PROV3, all new funds were strictly targeted for specific developments. These developments had to fall within national guidelines, and providers had to demonstrate the benefits accruing: 'All money is targeted, very little discretion there. A big emphasis on delivery including more follow up and monitoring.' (PROV3.interview, 19th August 1999). This had also become the norm in PROV/ DHA2: 'Previously there was emphasis on principles and values but the detail is new, drawn from both local good practice and national initiatives.' (DHA2. Interview, 30th June 2001)

We can now consider the issue of *personnel,* both in terms of posts and qualifications. In Prov1, in the early 1980s, two human resource strategies were implemented to ensure that staff were in the right place at the right time. The first strategy focused on staff in the closing hospital - their skills, interests and abilities were identified and put onto a simple database. As soon as any vacancies became available within the DHA, they were matched up with potential staff. The DHA guaranteed them an interview. This first strategy ensured that staff were motivated to plan their futures in the context of the NHS, even before community services started on the ground. A guarantee of no compulsory redundancies was negotiated with the trades unions, and this ensured that the 'early movers' had significant co-operation and support from a powerful pressure group. The second strategy focused on keeping key staff to run down the hospital. Certain staff were identified who were needed in the hospital in the medium term to maintain a minimum service. These staff were able to apply for other jobs within the DHA which would then be reserved for them for a period of up to one year. This bought the hospital time to run down its services without losing key staff all at once. It also ensured that talented staff were not lost to the NHS. (Personal archives, 1984). By the end of the 1980s in PROV2 circumstances were quite different. A parallel set of services had developed, with most of the trained and skilled staff working in the community, leaving a group of disaffected staff in the hospital. There were no guarantees of employment for staff left in the hospital, and so they were highly motivated to keep their services in use. This they attempted to do by the use

of referrals, crisis interventions and lack of communication and documentation between community and hospital. They were not included in local planning groups and were marginalised in hospital planning teams that had no formal link into the joint planning process. The community recruited staff from Social Services and other localities, leaving a very difficult human resource problem for the Personnel Director. Some staff left the hospital to set up profitable nursing homes for the mentally ill, creating significant conflicts of interest for staff still in the hospitals. (Personal archives, 1988.) The chief executive of the provider unit noted that in the late 1980s:

> We did a lot of re-training as staff moved to community settings. Some made the transition better than others. We only made 20 people redundant. With hindsight I'm not sure it (the HR transfer) was as good as it could have been. Recruiting community jobs was popular because it was prestigious and better paid. We had great difficulty in back filling posts in hospitals though.
>
> (PROV2. Interview, 3rd July 2001)

By the early 1990s in PROV2 and PROV3 the picture had changed again. The 'internal market' for health care had driven significant changes in the way services were developed and provided. A wide range of agencies were involved in the provision of care at a local level, and the provider unit was just one of many players, albeit still the biggest. When it came to managing multi agency teams, the arrangements were very complicated. According to the PROV2 Chief Executive: 'There were complex selection arrangements for the multi disciplinary teams, we actually moved to joint management in one team with a joint head. We sweated blood and it took ten years.' (PROV2. Interview, 3rd July 2001). The methods of provision and the type of staff involved in providing services had also completely changed. A diverse range of services such as counselling, psychotherapy, group-work, self-help groups and domiciliary support were provided from a number of agencies. (Personal archives, 1989.) The market of mental health staff had changed significantly over this period. Managing this complex chain of human resources and the risks involved as providers dropped in or out of the market became a key preoccupation for the Micro level but was also felt by the Meso level in terms

of linking strategy to the commissioning process, as noted by the DHA planner: 'On the strategic front it was completely divorced from the contracting process. This dogged us for years and years. How to link policy strategy to the annual contracts.' (DHA2.interview, 30th June 2001). By the late 1990s human resource issues were still as complex, although the emphasis on longer term planning encouraged providers to commit funds to recruit and train staff in a range of specialities, as well as providing more secure futures generally for mental health workers. The emphasis on joint working in PROV4 was strengthened by a series of joint health and social service appointments to lead the community teams. The Chief Executive commented: 'we have pooled our budgets, and appointed the best people for the jobs, irrespective of their professional backgrounds. It's about partnership.' IPROV4, interview, 17th September 2001)

Overall, human resource planning (in mental health services) was probably at its *easiest* in the early 1980s, despite the huge changes that started during this period. It appears to have been most *difficult* in the mid 1990s. However, there are still significant recruitment and retention problems, in certain areas of the UK, which reflect the general NHS picture. These problems are more connected with demographics and full employment than with mental health services.

The next factor to be considered is that of *accommodation: has the programme got enough? Will it need more?* In the early 1980s, in PROV1, the availability of bridging funds and the range of localities within which the new community services were created meant that there was plenty of space and land for new developments. By the late 1980s, in PROV2, the use of land and planing permission had become a real issue. There was no shortage of potential land for re- development in the community, but there was a growing concern from the local population who were unwilling to see mentally ill people being re-housed near to them. A series of public meetings were held to discuss residents' fears, and some initiatives, such as a 24 hour help-line, and a formal review process helped allay public concern. (Personal archives, 1989).

By the late 1990s, mental health advocates were much more vocal about the needs of clients, their rights to decent housing and support in their local community. The debate became more polarised, and significant tensions existed.

The final factor in this category is that of *supplies and technical equipment*: were they available and usable and how important is technology? Initially, in PROV1, the community mental health services were viewed as fairly low tech. But by the early 1990s, in PROV2 there were significant technical demands for child and adolescent services. As psychiatrists set up community based child and family services, they needed sophisticated CCTV systems, which cost almost as much as the combined staffing budget for one year. The lead Consultant in PROV2 chose the most expensive equipment she could find, and then justified her bid for funds, by describing it to DHA members as her 'operating table.' The funds were made available without further ado and the senior manager at the time was overheard commenting that it was a small price to pay to keep the medical staff 'on board.' (Personal archives 1989). This is an interesting but unusual example of the way in which professionals could use language to increase their power and resources, in this case by making direct comparisons between their psychiatric work and the work of a general surgeon. It was unusual precisely because high-tech equipment was not normally utilised by mental health workers. Overall, community based mental health services are still perceived as low-tech services, particularly when providing services for people with long term, enduring mental health difficulties.

7.2.3 Difficulties arising from the programme manager's need to share authority with or retain the support of other bureaucratic and political actors.

The first and perhaps most obvious factor to consider under this heading is that of *other agencies*: how many do managers have to deal with, and how supportive are they? There are, as might be expected, some chronological

differences in this respect. In PROV1, the NHS provider unit did not have to deal with other agencies to any great extent, though the lack of involvement was seen as a weakness by the Chief Executive: 'In hindsight we should have worked more closely with social services' (PROV1.interview, 1st November 2000). In Prov2 the involvement with other agencies was significant, although most of the resources were coming from the hospitals and as such were controlled by the NHS. However, new money, such as the MISG, came with strings attached – the agencies were required to work together, to access the grant. (Personal archives 1989). In Prov3, and the advent of the internal market, the picture was even more complex. The lead agency (the NHS) was required to work with and involve other agencies, and even to give away and retrench their own services in order to build up the new pattern of community based care. This created significant tensions between the NHS and other providers, and much of this tension had to be managed by the Meso level. Although the Meso level was not directly involved in delivering services, their involvement through the contracting process, as referee and umpire, awarding and taking away contracts on an annual basis means that they had a significant impact on service provision. They dictated the shape of the service, who delivered it and how long for. In Prov2 and PROV4, at the turn of the century the involvement with other agencies has transformed into a more complex and interdependent relationship. The Chief Executive of PROV4 noted:

> There's greater maturity now. In the last eighteen months, we've moved away from a polarised, entrenched position, to a more generic focus on activity ... it's much more relaxed. This has been in spite of the increasing control and pressure to perform from the centre.
>
> (PROV4, interview, 17th September 2001)

The emergence of primary care teams led by GPs and the abolition of the DHAs is of grave concern to provider units according to the DHA2 planner: 'Trusts are very worried – strategic health authorities will be very remote. Primary care teams will have to get going very fast.' (DHA2. Interview, 30th June 2001.) Whilst some of the DHA staff have transferred to the PCTs, the

boundaries are different, the key players, such as general practitioners, are new to this field and the multi-agency roles are also untried.

A second factor to consider centres on *elected politicians*: could they help or hurt? In the early 1980s the role of local politicians in PROV1 was almost non-existent, and in PROV2 the main involvement of local politicians was through the social services committee structure. They controlled all the resources, and there was much more local political accountability and control through social services than through the NHS. (Hurford, 1990). The main effect of this control was that of time-scales. Resource applications to social services for new mental health schemes would take months of planning and negotiating. In the NHS, this process was much quicker and was usually at the discretion of the provider chief executive. (Personal archives, 1990.) In PROV3 and 4, there was less involvement of local politicians in the NHS as local councillor seats had been abolished on the DHA in the management reforms of the early 1990s.

A third factor to consider is that of *private sector providers*: how strongly did managers depend on them and how were they controlled? In the early 1980s there was no private sector provision replacing the hospital services, although the advent of compulsory competitive tendering (CCT) did affect ancillary and support services in the NHS generally. However, PROV1 requested (and gained) special exemption from the Regional Health Authority from the CCT process in the 1980s. They gained this exemption on the grounds of the major restructuring and upheaval that was already underway in the unit. However, this was gained with some difficulty and is an example of the supporting role provided by the DHA District Administrator at the Meso level at that time. (Personal archives, 1984.) By the late 1980s in PROV2, there was growing involvement of housing associations, charitable foundations and the private sector in the provision of residential and day care services as well as drop in centres and counselling/ self help groups. As we have noted (Chapter Five, Section 7) these bodies became dependent on the NHS for contracts as a result. The extent to which this ideology has taken root at the Meso level by

DHA2 planners can be noted as significant, as this is one of the few 'political' statements that have been made at this level: 'We are fully committed to a mixed economy of care. The voluntary/ profit sectors can do better than the traditional NHS.' (DHA2.Interview, 30th June 2001). By the 1990s, the advent of the Private Finance Initiative (PFI) had made significant inroads into the provision of new buildings and capital equipment and this had significant implications for most provider units. Control of new build schemes in the NHS was taken away from the provider units and was taken over by private companies. The new Labour government in the late 1990s continued this programme. An important point to note arising from this analysis of mixed sector provision is that the process of implementation is spreading out amongst various bodies and organisations. If the Macro level wishes to have any control at all across such a diversity of agencies and groups, anything *except* a completely prescriptive top-down approach may not be feasible. However, arrangements for monitoring the different agencies are fraught with difficulty as some DHA planners are concerned about the gaps: 'We haven't been good at monitoring quality, the care management review was not brilliant.' (DHA2.Interview, 30th June 2001). On the other hand, the Institute of Health Services Management notes the problems faced by small voluntary sector providers in meeting the same quality criteria as NHS Trusts and local authorities: 'Smaller agencies may find the range of systems with which they are required to comply onerous. Nevertheless it may be considered inappropriate to place identical demands on the two kinds of organisation. It may be that quality controls need to relate to the risk involved.' (IHSM, 1999: 29). Whilst this is not a government document, as a recommendation from a significant professional group it has been taken into account by Macro policy makers. (IHSM Conference, 1999.) There may well be different requirements on control and monitoring, based on the size of the organisation concerned and the element of risk involved to clients and this could be one way in which the Macro level begin to cope with the range and complexity of new providers coming into the 'market'.

A fourth factor is that of *special interest groups*, their interests and political influence.

Special interest groups at provider level were almost non existent in the early 1980s, but by the late 1980s there was some pressure group activity in Prov2. By the mid 1990s the pressure groups of clients and the role of the consumer was going from strength to strength. locally. A number of advocacy posts were funded in DHA2 and PROV3, and users were co-opted onto many hospital and community planning groups. This process was continued and extended in PROV4 in 2000-2001, with users getting involved in appointment committees, and in service reviews. (PROV4 Interview, 17th September, 2001.) This high profile of consumer pressure groups has also included representation on the new primary care teams, with mixed success. These PCTs are led by doctors who wish to focus on very professional methods of mental illness evaluation and treatment. Users have been co-opted onto these groups but at the expense of their involvement at the Meso level, which will anyway be abolished in 2002. Pressure groups such as MIND who have locally been involved in delivering services over the last decade still experience some conflict of interest between their contractual obligations as providers and their pressure group activities as user representatives. (Personal archives, 1989-2000)

A fifth factor to consider is that of *the media*: will the programme have high visibility? Could the press do any harm or good? The role of the media in mental health issues has been very well researched by Ramon (1997) but as far as the provider units used in this research were concerned, there was very little media activity or interest in the 1980s with the 'early movers', although by the early 1990s media activity and interest had grown. The influence from the point of view of providers in PROV2 was seen to be largely negative, and there was an acknowledgement that 'crises' were picked up by the media if they were 'one off' rather than if they were frequent cases as noted by a chief executive after a particularly difficult encounter with the Press. '(The Department of Health) has had so many cases now that these things almost go

un noticed. Timing plays a factor.' (PROV2.interview,3rd July 2001). At the Meso level, by the mid 1990s, a much more active policy of media management had officially been adopted. According to their planner: 'We try to deal with queries quickly and appropriately, we have a PR person' (DHA2.interview, 30th June 2001). This was not seen to be the Meso policy from the provider's point of view though. The chief executive in PROV2 noted that when a crisis arrived: 'Actually it was the Trust solicitor who gave us the most help. Region behaved like pigs. Concerned only to save their own skin. The DHA tried to keep out of it altogether' (PROV2.interview, 3rd July 2001). This tension between the Meso and the Micro level suggests that there is little evidence that the media and the press can have an overt influence on policy. However, they may be able to *slow things down* (by the demand for consultation or public meetings) and they most certainly can *damage relations* between the Micro, Meso and Macro levels. This damage, whilst not necessarily evident to the outsider, may affect the ability of the Meso level to assist the Micro level in shaping and implementing policy, because of a deterioration in trust between the two levels.

When we analyse the *range of agencies* involved in the implementation process, it is clear that it has grown considerably over the last twenty years. Pressure group activity has been supported at the Meso level since the early 1990s, putting some pressure on the Micro level and is now also focused at the new local planning team level. The proposed abolition of the Community Health Councils in 2001 and the creation of NICE (National Institute for Clinical Excellence) suggest that there is likely to be significant re centralisation of policy evaluation. However, the much heralded NICE conference on mental health in June 2000 did not fulfil its promise. The keynote speaker attended but did not speak about NICE criteria for measuring mental health services, as 'no-one had agreed them yet.' (NICE/conference. June 2000). Whilst the effectiveness of mental health policy is not the subject of this research, the methods by which the Macro, Meso and Micro level attempt to gain control of the measurement agenda tells us a lot about power and influence in the field.

Overall then, mental health policy implementation has become more complex and more difficult over the intervening years. The recent sea change in the way in which policy was implemented locally in the mid 1990s gave the DHA some space and time to create and re-shape provider policies and politics. This space was short-lived however. With the arrival of a new Government in 1997, the Macro level began to plan from the top down in earnest.

7.3 Methods of policy implementation and difficulties encountered

This third section considers the relationship between the method of policy implementation adopted and difficulties encountered by provider managers, taking into account the chronological differences in the four overlapping case studies. Certainly, the bottom up approach to policy implementation evident in the early mover case (PROV1) in the early 1980s appears to coincide with less complexity of actors and agencies in the implementation process. As policy implementation became more of an evolutionary process for PROV2 in the late 1980s, there were some new pressures, such as CCT and the emerging role of social services in planning and providing services. Probably the most difficult (and most interesting) time for provider managers in policy implementation terms lay in the early to mid 1990s with the introduction of the internal market and a more 'political game' approach to implementation. Then the providers had significant *potential* to shape and change policy as it was implemented, but they were not as isolated as the 'early movers'. This potential was of course mediated by the Meso level and was contingent on the skills, knowledge and expertise at both levels. This was not just technical skills and knowledge. A planner in DHA3 noted: 'technical skills are important but because relationships are not clear, interpersonal and leadership skills are absolutely critical.' (DHA3.interview, 4th June 1997). It is tempting to view the mid 1990s as a period of 'balance' between the Meso and the Micro level when norms had evolved, roles had become flexible and conflict had been dissolved, in other words when the two levels were working as a

team. Certainly there is some evidence for this view if we examine the comments of the DHA2 planner on the contracting process for the year 2000:

> In the last round we had a good settlement. We had had difficult discussions on the K Hospital closure. Because we were clear about our objectives mid year, when we came to the SAF (Strategic Framework) discussions we knew what we needed. Everyone was in agreement. A big recurrent investment was needed for the elderly mentally ill; there was a consensus, developed with the independent sector. We wouldn't have got the finance (from Region) if there had not been clarity and agreement locally.
>
> (DHA2.interview, 30th June 2001)

This perspective is confirmed by the retiring chief executive, as he commented: 'The last year of contracting they (the DHA) were very short of money so moved away from conflict – and we tried to work together, much more open, much more effective.' (PROV2.interview, 3rd July 2001).

Whether or not the Meso and Micro levels in DHA2 had worked out the most productive method of policy implementation as a 'political game' will never really be resolved because the rules have changed again. As we start the next century there is no doubt that providers and planners alike consider that policy implementation has become a 'top down' process, perhaps for the first time in the history of the NHS. The implications of this, as it affects the cycle of policy initiation, formulation and implementation are discussed in the following chapter.

CHAPTER EIGHT:
CONCLUSIONS AND THE IMPLICATIONS FOR POLICY MAKING IN THE UK

Introduction

In this Chapter, the main findings of the thesis on how policy works at the Macro, Meso and Micro levels will be considered, as well as the way in which the three levels interact in these processes. These findings will then be contextualised through the use of the conceptual framework discussed in Chapter Three, namely the Venn diagrams, and the matrix. The implications of these findings and their relevance to the wider policy debate in the UK will also be discussed.

8.1 How does policy work at the Macro level?

At the Macro level, mental health policy has historically been shaped through anti-pluralistic behaviour, with the government rarely getting involved except to arbitrate in disputes, and to act as an impartial umpire. The exception to this pattern occurred once in 1969 when the Minister for Health took unprecedented action (*The imperative to act*). The main agenda setters in mental health services can be plotted on a chronological time trend, commencing with doctors until the 1950s(through their non decision-making and indifference), to other professionals through the 1960s (through the use of new ideas and a elitist approach to policy initiation), to politicians at the end of the 1960s (through interests, ideas and a 'legitimation crisis') to general managers at the NHS Executive from the late 1980s(through covert power and cultural manipulation) and finally to national user groups from the early 1990s (through a neo-pluralistic process of consultation, but 'after the fact'). Agenda setters exerted power at a variety of levels (but most actively and effectively at the covert level.) They were actively involved in pursuing interests, but ideas had a part to play and ideas tended to precede interests. But the overwhelming evidence suggests that covert power allied to the use of

language was at least as important to politicians as substantive aspects of policy. The evidence suggests that politicians, professionals and managers have been manipulating actors and using language and symbols to promote change since that early decision point by Crossman, back in 1969. After a fairly 'dormant' period between 1969 and 1983, the Macro level has again got involved in initiating policy. This has been achieved through the Meso level in the early 1980s by using the Review process, and at arms length through the introduction of general management into the NHS that quickly followed. An unlikely coalition of managers and politicians more than any other group have since profited by this use of covert power in the last twenty years. The way that they write policies, the methods for framing research initiatives, the structures that are put into place for funding arrangements and the shorthand ways in which they refer to policy objectives tells us as much about their political preoccupations as their substantive policy choices.

The process of policy formulation is similarly haphazard, based, as it is, on responding to interests. It is shaped by the 'process' culture at the top of the NHS organisation. There is overwhelming evidence that, when the Macro level has historically engaged in policy formulation, it has done this as a selective response to interests. This is partly a reflection of the power structures within which the NHS organisation is located. However, this formulation has been carried out within an extremely strong ideological framework. Policy making as the product of a rationale is notable by its absence. The Macro level rarely if ever gets involved with policy implementation (defined as the point of delivery in this study, as summarised in Chapter Three.) The exception to this lack of involvement is when there has been a crisis, or when the Micro level has appealed to the Regional outpost of the Department of Health over contractual negotiations with the DHA.

The recent change in government in 1997 has, however, changed the policy climate significantly. The Macro level is driving policy initiation by setting the agenda at a political level with two 'big ideas': stressing the importance of the *mixed economy* approach in the provision of services by the inclusion of the not

for profit and the private sectors and emphasising the values of keeping people in their *own homes* for as long as possible. The policy initiation process could therefore be described at the end of the century as driven by *ideas*. The Macro level is also now actively involved in formulating policy, and this extends to the *detail* of structures and staffing levels for different types of clients. The policy formulation process could not be described as a 'completely' rational approach in that it is very much driven by the interests of advocates of community care, but it is a logical process in that it fits closely with the way the Macro level are currently dealing with ideas in the policy initiation stage. However, there is evidence that an inflexible approach to policy formulation can create internal contradictions and reduce the rational nature of planning at a local level. Overall the Macro level has become much more directive over the last three years, at least in the perception of the two DHAs consulted in this research. The current political emphasis on improving public services is also likely to keep the Macro level fairly 'hands on' for the duration of this next Parliament.

8.2 How does policy work at the Meso level?

At the Meso level, mental health policy activity is quite different. There have been significant points when individual actors have shaped changes, by two methods. The first method is through the transmission of ideas and the second method is through the use of covert power allied with technocratic interests. The broadly utilitarian approach to policy initiation has been more recently (since the 1990s) mediated by the use of consumer involvement, though this is in its infancy. At the Meso level, agenda setters in mental health services have shifted considerably. The early hegemony of doctors and bureaucrats (as an elite) had changed to a re-energised and re-defined professional group of technocrats, most of whom were making real efforts to include pressure groups and consumers in the process of policy initiation. All groups were actively involved in pursuing interests but ideas also had a part to play. There was evidence of quite strong mental health communities or networks at the Meso level, which were not apparent at the Macro level. There was also evidence of significant exchange of ideas between the Meso and Macro level,

whilst the presence of a mental health network at the Meso level seemed to dilute the covert methods of power which were potentially available to professionals and planners. There has been more opportunity and time for critical analysis of ideas at the Meso level than at the Macro level. There has also been a very robust response, until recently, to any attempts of the Macro level to impose ideas for mental health systems. The Meso level has not spent time or attention on these unless they were backed up by well researched data and mediated by policy brokers who had expertise in the field of epidemiology. The formulation of policies is conducted in a broadly rational manner, with some reference to interests and procedural considerations, but less than might have been expected given the more interest driven approach at the Macro level. The Macro level appears to have exerted very little control over the Meso level with the exception of deadlines for statistical returns (and these are often inaccurate.) There is no mechanism for checking the content of such returns, nor does the Macro level show any interest in carrying this out. I have argued in Chapter Five that the Meso level adopts a very 'robust' approach to policy initiation and the evidence that we have considered in Chapter Six confirms that this approach continues through the process of policy formulation, despite the pressure to include interest groups. Meso level planners and managers have become more sensitive to the needs of users and pressure groups, but the general impression from their language, methods of working and actual policies denotes that they have a strong sense of their own expertise and mandate that has, until recently, been strengthened in the intervening years of this study. The advent of the internal market in 1991was a particularly effective mechanism for increasing policy activity at the Meso level, because of the significant new contracting powers ceded to this level. A risk however that has emerged is that the pressure groups (which are now also providing services) are in a relatively weakened position, dependent as they are for resources and jobs on the Meso level. There is however evidence that users are more consulted and included in the policy process at this level than at any other time in the history of mental health services. A further risk is that the quality of management at the Meso level is now so important, that badly managed DHAs will deteriorate very quickly, because the providers will 'run

rings round them' and provide what they like, essentially as a monopolistic supplier. However, this risk is probably no higher than in the past and is mediated by other voluntary and private sector suppliers who have entered the market.

This state of affairs is, however, changing significantly, as the Macro level has become much more directive over the last three years. The recent introduction of primary care teams led by general practitioners has devolved planning and resource powers to a more local level (not to be confused with the Micro delivery units.) Whilst this is a very recent initiative, there is already a confirmed plan to abolish the DHAs, leaving just 30 strategic health authorities and taking out the entire Meso level by April 2002. There are serious implications to this, not least for District wide services. Whether the new local primary care teams will be able to co-ordinate and plan for such small populations is a matter of heated debate at present.

8.3 How does policy work at the Micro level?

At the Micro level we have seen the most profound changes in the way policy activity is conducted. There is the potential for all policy activity (initiation, formulation and implementation) to occur. In the 1960s there was no evidence of policy initiation occurring, precisely because there was a very strong status quo. In the early 1980s there is evidence that some providers, *in conjunction with the Meso level,* initiated, formulated and implemented policy in the space of three to four years. The case of the 'early mover' that was studied demonstrates the vital collaboration between the Meso and Micro levels in this respect. Whilst the environmental factors were similar to other provider units across the UK, the personality of the District Administrator (the DA) at the time appeared to be a driving force in shaping change in this DHA/provider unit. The Macro level did not select this DHA as such and the intermediate RHA was perceived to be particularly unhelpful in assisting the change process. From this analysis, we can see that the role of the DA was key. However when he was appointed to head up a task force to duplicate the effect

nation-wide, this proved more difficult. We can conclude from this that individuals can have a significant impact in policy activity at the Meso level but this influence and power wanes as individuals move up the hierarchy. There appears to be an invisible ceiling beyond which individuals struggle to shape their organisation, and this is located at the Meso level. At the Micro and Meso levels, there is evidence that managers and professionals can have a significant cultural effect on their teams and their units but at the Macro level, the *discourse* of officials excludes any reference to this type of cultural autonomy. If Macro level individuals are shaping their organisation, they are doing so unknowingly. There were plenty of examples of Micro actors in other DHAs who were enthusiastic for change. However, they could not move forward because this enthusiasm and commitment was not shared at the DHA Meso level. The general finding from this is that *the quality of management at the Meso level* is crucial to any *major shift* in policy activity. The quality at the Micro level is also important, to assist in making things happen but the quality of management at the Macro level seems immaterial. When other DHAs are following on behind, the quality of the Meso level seems less important; then (as we have noted in DHA/PROV2) all the activity centres at the provider (Micro) level, and the quality of management at this Micro level is what counts.

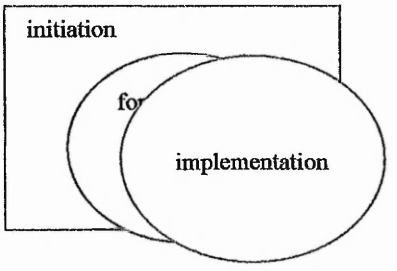
When we consider the process of policy implementation at the Micro level, the bottom up approach, evident in the early mover case (PROV1) in the early 1980s, appears to coincide with less complexity of actors and agencies. As policy implementation became more of an evolutionary process for PROV2 in the late 1980s, there were some new pressures, such as CCT and the emerging role of social services in planning and providing services. Probably the most difficult (and most interesting) time for Micro provider managers in policy implementation terms lay in the early to mid 1990s with the introduction of the internal market and a more 'political game' approach to implementation. Then the providers had significant *potential* to shape and change policy as it was implemented, but they were not as isolated as the 'early movers'. This potential was of course mediated by the Meso level and was contingent on the

skills, knowledge and expertise at both levels. It is tempting to view the mid 1990s as a period of balance between the Meso and the Micro level when norms had evolved, roles had become flexible and conflict had been dissolved, in other words when the two levels were working as a team. Whether or not the Meso and Micro levels in DHA2 had worked out the most productive method of policy implementation as a 'political game' will never really be resolved because the rules have changed again. As we start the next century there is no doubt that providers and planners alike consider that policy implementation has become a 'top down' process, perhaps for the first time in the history of the NHS. The implications of this, as it affects the whole process of policy initiation, formulation and implementation are discussed in the following sections.

8.4 Putting the findings together: From chaotic to dynamic worlds and beyond.

If we re-visit the Venn diagrams posited towards the end of Chapter Three, we can now see which DHAs and Provider units fitted into which models. Commencing with the 'early mover' it is clear that this unit was quite unusual. In the early 1980s DHA1/PROV1 fitted the fractal model:

The fractal model: C

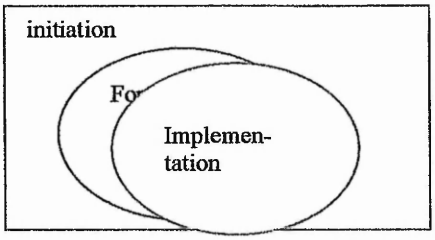


In the fractal model, we are operating on the borders of chaos. The implementation stage opens out the policy agenda and also has significant spill-over effects into other policy areas. Actors are 'learning by doing'. Three spill-

facilities for child and family services, psychotherapy and other counselling services that had emerged in the 1980s, led by the new cadre of professionals such as psychologists and community psychiatric nurses, social workers and some medical staff. The other completely new area to emerge in the late 1980s was the drug and alcohol addiction service, led by consultants and closely linked to general hospitals through the Accident and Emergency units. Areas that were often discarded included the early emphasis on drug therapies, which were partly replaced by different therapeutic interventions such as counselling and self help groups. Another concept that was briefly part of mental health policy but was quite quickly discarded was that of 'sanctuary': a place where mentally ill people could be placed for their own safety or the safety of others but not necessarily treated.

In the 'contract culture' we can observe that as providers and the DHAs became more balanced in terms of skills and knowledge in the mid 1990s, whilst they were still operating in a 'dynamic model', the gap between policy formulation and implementation had narrowed, so that it could be modelled thus:

The dynamic model: B1

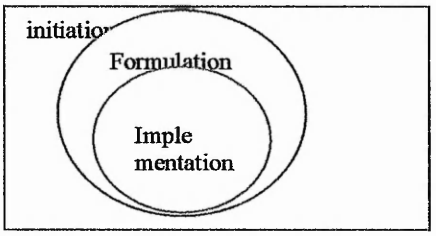


In this model, whilst there was some difference between the intended and the actual policy, this was 'at the margins'. The Meso and Micro levels were working closely together and in DHA2 and DHA4 at least, had achieved some core common purpose, had similar objectives and were developing some measures for success. These were notably the involvement of user voice, not just

in evaluating but in planning services. The units had moved some distance from the early 1990s, when both the Meso and then the Micro levels listened to users and then continued to do what they had originally planned.

However, the very real shift in approach by the incoming government in 1997 has translated into a much more top-down approach that would fit what we originally dubbed the 'reductive' model:

The reductive model: A



This 'reductive' model has two subsets, closing down options, operating within certain boundaries, reducing choice and constraining growth. The model fits the current mental health political climate very well, because government policy is being followed to the letter. But the result is always less than originally expected, because of the negative power we have identified: *to slow things down or to stop things happening.* We are witnessing managers and planners *doing things right* instead of necessarily *doing the right thing.* (Drucker, 1985). Mental health policy making is now less than the sum of its parts.

Now that we have examined the interaction between policy implementation, formulation and implementation over the last twenty years, we can consider which of these activities has been carried out by each of the three levels: Macro, Meso and Micro, over the last thirty years.

8.5 What happens where? Filling in the matrix.

In Chapter Three the following matrix was constructed to analyse what policy activity occurred at the various levels of the organisation. There were many areas that were unclear, but it is now possible to complete this matrix as follows:

Matrix from chapter 3: (M1)

M1	MACRO level	MESO level	MICRO level
Policy initiation Occurs	?	?	?
Policy formulation occurs	Yes	?	?
Policy implementation occurs	No	No	Yes

What we can see from the findings is that this matrix is going to vary depending on contingent factors. There is activity which necessarily occurs (Yes), and there is potential for activity to occur (P). Finally there are activities that never occur (No). The new completed matrix is as follows: (M2)

M2	MACRO level	MESO level	MICRO level
Policy initiation Occurs	P	P	P
Policy formulation occurs	Yes	P	P
Policy implementation occurs	No	No	Yes

The potential areas will vary. For example policy was initiated at the Macro level during the 'imperative to act' in 1969. Policy was also jointly initiated and formulated at the Meso and Micro levels in DHA1 in 1983. In the later movers, we can see that policy was also formulated at the Macro and Micro

levels. In the contract culture era of the 1990s, we can see that policy was formulated, perhaps more at the Micro level to start with but later between the Micro and Meso levels as knowledge and skills balanced out. The Micro level has traditionally shaped and changed policy as it implemented policy, and has often carried out all three stages at the same time (particularly at the beginning of the contract culture.) More recently the Macro level has initiated and formulated policy that has then been left to the Micro level to implement, cutting out the Macro level altogether. We can show all this activity through a series of matrices as follows:

The 'imperative to act' at the Macro level in 1969 can be modelled as follows: (M3)

M3	MACRO level	MESO level	MICRO level
Policy initiation Occurs	Yes	Yes	Yes
Policy formulation occurs	Yes (Political)	No	No
Policy implementation occurs	No	No	No

Crossman's (Secretary of State for Health) decision in 1969 to publish the critical findings of the Ely Hospital Inquiry and the creation of a Health Inspectorate triggered the end of policy initiation (which all levels had contributed to) and commenced the ideologically driven policy formulation process which resulted in the concept of 'care in the community'. This formulation process was not shared by the majority of professionals, (who were pressing for psychiatric service provision in general hospitals). Overall it is important to note that the Macro *politicians* triggered the process of policy formulation, rather than the *civil servants* at the Macro level who wished to suppress the Inquiry's findings. Policy was not significantly shaped by the Meso or Micro levels during this time and the process of implementation did

not commence until the early 1980s. Until then the care in the community policy lay dormant.

Moving forward to the *early mover* DHA/PROV1 (in the early 1980s) the policy process can be modelled as follows: (M4)

M4	MACRO level	MESO level	MICRO level
Policy initiation Occurs	No	Yes (joint)	Yes (joint)
Policy formulation occurs	No	Yes (joint)	Yes (joint)
Policy implementation occurs	No	No	Yes

In the early 1980s, there was very little activity at all at the Macro level. The Region was advising the DHA to 'keep their heads below the parapets' and all the policy initiation and formulation activity was going on (jointly) at the Meso and Micro level in DHA/PROV1. The provider unit was also implementing policy for the first time.

If we now consider the *later mover* DHA2/PROV2 in the late 1980s, the policy process can be modelled as follows: (M5)

M5	MACRO level	MESO level	MICRO level
Policy initiation Occurs	No	No	Yes
Policy formulation occurs	No	No	Yes
Policy implementation occurs	No	No	Yes

In the late 1980s in PROV2, the DHA was much less involved in policy initiation and formulation, although it did issue limited guidance from time to time. It also stepped in and assisted with funds in the early 1990s. The majority of the policy activity occurred at the Micro level, through a steering

group led by the chief executive and supported by local planning groups. There was very little policy making occurring at the Macro level that impinged on the Micro process.

Moving forward to the 1990s, the *'contract culture'* (DHA/PROV2 and DHA/PROV3) can be modelled as follows: (M6)

M6	MACRO level	MESO level	MICRO level
Policy initiation Occurs	Yes	Yes	Yes
Policy formulation occurs	No	Yes	Yes
Policy implementation Occurs	No	No	Yes

In the early 1990s in DHA2 and DHA3 there was limited Macro policy activity, through the issuing of health improvement targets and Health of the Nation guidelines but this information could to a certain extent be taken or left by the Meso level, and as such shaped policy discussion but did not dictate the detailed policy that was then formulated. So the Macro level could be argued to be involved in policy initiation, rather than policy formulation at this time. The Meso and Micro levels were both involved in policy initiation and formulation, although there is some evidence that the Micro level tended to dominate the policy discussions in the early years of contracting. By the mid 1990s, the Meso level had grown in skills and confidence, and made significant changes to policy that were then implemented by the Micro level.

By the late 1990s, *'Under New Labour'* (DHA/PROV2 and DHA/PROV4) can be modelled as follows: (M7)

M7	MACRO level	MESO level	MICRO level
Policy initiation Occurs	Yes	Yes (ltd)	No
Policy formulation occurs	Yes	No	No
Policy implementation occurs	No	No	Yes

By the late 1990s in DHA2 and DHA4, we can observe that the majority of policy direction was emanating from the Macro level. They were initiating new policy ideas and directing much of the formulation of policy in great detail. The Meso level still struggled to initiate policy discussion (such as user involvement, and counselling services) but had little support (financially) from the Macro level for such initiatives. The Micro level was being much more directed from the Macro level, and saw its role as that of implementing Macro policy as best as it could, in these quite restricted circumstances: 'There is very limited latitude for managers now.' (PROV4 interview, 17th September 2001.)

The significance of these varying compositions of policy action is that no particular level has held a monopoly on policy initiation or formulation throughout the last thirty years. The balance of policy activity has shifted considerably between the different levels, for a variety of reasons. Whilst there are obvious forces shaping policy activity such as power and interests, it is important not to underestimate the role of ideas and culture in shaping policy as well. This is particularly important when considering the way in which organisations shape individual actions, and the way in which individuals are able to shape the wider organisation.

8.6 Mental health policy making – wider implications

Much of what has been discovered and discussed is peculiar to mental health services, and within that area, to four DHAs and provider units. However,

there are certain points that can be extrapolated into other areas of policy making. The Government that is pursuing such a 'top down' approach in mental health services is also responsible for other public services. These recent findings (post 1998) in mental health policy making are a reasonable reflection of what is happening across the whole of the NHS, and Social Services as well, if the DHA planners are to be believed. Certainly that is how it is perceived at this Meso level.

Because much of the evidence collected is based on semi-structured interviews, these findings tell us how policy actors feel about their work, their colleagues and their politicians. It also tells us what they consider to be important, what they think they should be spending their time doing, their aspirations and their values. This brings us to a particular dilemma. By the late 1990s, the Meso and the Micro levels in at least two health authorities appeared to have found a rather unique balance of policy debate, that brought out the best of each level and increasingly included consumer voice. The imposition of a new top-down approach to policy making with the Labour Government does therefore give cause for concern, because, if successful, it will limit local discretion. I have argued that managers have less influence at the Macro level than at other levels and have suggested that the institution is less of an 'edifice' at the Micro and Meso levels. Managers at these levels, however much their discretion is curtailed in policy formulation by edicts and dictates from the centre, have not had to struggle with the invisible institutional pressures to the same extent as their Macro level colleagues. However, this recent top down approach from the Macro level will necessarily reduce their discretion and choice in the policy process and will also reduce the likelihood of generating new ideas and models for provision.

The values held at the centre and the ideologically driven policy measures, are judged to be sufficiently appropriate by actors at the Meso and Micro levels, so that, for the present at least, there is enough consensus and trust between the levels to ensure mental health policy will not falter. But this is a fragile kind of consensus, and as soon as finances become tight again, or any

significant ideological differences emerge between the two levels, guerrilla warfare may ensue, through the use of negative power. Negative power is commonly deployed by individuals who do not possess other forms of power, so the top down approach does tend to build this reaction into the policy process. Mental health service planners at the new local level and providers at the Micro level may not deviate from the government 'line', but they are most unlikely to create anything surprising or to generate new ideas in this type of 'top down' culture. At each stage, policy making becomes a mere subset of the preceding stage. Mental health policy making across the three levels is now: *'Less than the sum of its parts'*. In a turbulent environment, we can ill afford to stand still in the mental health policy making field and we may have to look, once again, to other countries for new theories and ideas. This is probably the biggest implication of all and if we extrapolate this effect into other parts of public services, the Government's stated aim of modernising public services will be severely compromised.

Summary

This research has achieved five objectives. It has developed a matrix for exploring the interactions between the policy stages and policy levels; it has modelled a series of ever- decreasing circles of bottom-up to top-down control; it has answered the question 'why was there an early mover?' and found that there was nothing special about provider 1, but that there was something special about the relationship between provider 1 and DHA 1; it has identified a glass ceiling for managerial power and discretion in mental health services that is located between the Meso and Macro levels of the organisation. Finally the research has shown the importance of a narrative structure when investigating policy issues over a protracted period of time.

***

BIBLIOGRAPHY

BIBLIOGRAPHY
Primary References

Audit Commission (1985) *Making a Reality of Community Care,* London: Audit Commission.

Audit Commission (1998) *A Fruitful Partnership: effective partnership working,* London: Audit Commission.

Council of Europe(1993) *European Co-operation concerning epidemiological studies in the field of mental health.* Strasbourg: Council of Europe.

Committee of Inquiry (1969) *Ely Hospital Report* CMND 3975, London: HMSO.

Department of Health (1986) *Joint Planning proposals and advice* (Advance Letter HC (FP) LAC.), London: HMSO.

Department of Health (1989) *Working For Patients,* London: HMSO.

Department of Health (1989) *Caring for People: Community Care in the Next Decade and Beyond* (CM.849), London: HMSO.

Department of Health (1990) (*The Griffiths Report) Community Care: Agenda for Action,* London: HMSO.

Department of Health (1992) *The Health of the Nation,* London: HMSO.

Department of Health (1994) *Mental Health Task Force, Local systems of support: a framework for purchasing for people with severe mental health problems,* London: HMSO.

Department of Health (1996) *Mentally disordered offenders: Sentencing and discharge arrangements,* (RMHLG/5), London: The Stationery Office.

Department of Health (1997a) *Developing Partnerships in Mental Health,* London: The Stationery Office.

Department of Health (1997b) *The new NHS, modern, dependable,* London: The Stationery Office.

Department of Health (1998a) *Modernising mental health services: safe, sound, supportive,* London: Department of Health.

Department of Health Press Release (1998b) *Dobson outlines third way for mental health (*98/311) 29 July.

Department of Health and Social Security (1975) *Better Services for the Mentally Ill* (CMND.6233), London: HMSO.

Department of Health and Social Security (1976) *Priorities for Health and Personal Social Services in England: A Consultative Document,* London: HMSO.

Department of Health and Social Security (1977) *The Way Forward: Further Discussion of the Government's National Strategy,* London: HMSO.

Department of Health and Social Security (1980) *Organisation and Management Problems of Mental Illness Hospitals* (The Nodder Report), London: HMSO.

Department of Health and Social Security (1981a) *Consultative Document: Care in Action,* London: HMSO.

Department of Health and Social Security (1981b) *Care in the Community,* London: HMSO.

Department of Health and Social Security (1983) *Care in the Community and Joint Finance,* London: HMSO.

Department of Health and Social Security (1986) *Mental Health Enquiry* HMSO

Dobson, F. (1998) in *Hansard* 8 December

House of Commons, Fifth Report of the Health Committee (1999) *The Relationship between Health and Social Services* (HC 74-1), London: The Stationery Office.

House of Commons (1988) Session 1987-88. *The Government's White Paper on Public Expenditure: The Social Services*, HC 702, London: HMSO.

House of Commons, Second Report of the Social Services Committee, *Community Care with Special reference to Adult Mentally ill and Mentally Handicapped People,* Session 1984-85, HC 13-1, London: HMSO.

House of Commons, Fifth Report of the Social Services Select Committee *The Government's White Paper on Public Expenditure: The Social Services*, Session 1980-81, HC 702, London: HMSO.

House of Commons, Third Report of the Social Services Select Committee *Report on Care in the Community,* Session 1981-81, London: HMSO.

National Audit Office (1987) *Community Care Developments,* London: HMSO.
Regional Mental Health Leads Group (1996) documents as follows:

Agendas, March, May, July 1996.
RMHLG working papers: 4(96) *Integrated working* Consultation q document.
RMHLG working papers: 5(96) *Combined hospital order/ custodial sentence (hybrid order) under the Mental Health Act* Consultation document.
RMHLG working papers: 6(96) *Effective Partnerships between Health Authorities and Local Authorities.*
RMHLG working papers: TB 282 *Emergency Services and the Challenge Fund.*

Personal archives:

Diaries: (1983-1990)
Personnel records: Exeter (1983-85)
Joint planning papers: Southern Derbyshire Health Authority (1987-1990)
Minutes of strategic planning meetings: SDHA (1987-1990)
Conference notes: Institute of Health Services Management (1990, 1994)
Training notes: Nottingham, Cumbria (1991-99)
Overhead / flipchart summaries of groupwork: Nottingham, Cumbria (1991-99)
Email analyses, Department of Health (1996)

Secondary references

Alford, R. (1973) *Health Care Politics,* Chicago: University of Chicago Press.

Allsop, J. (1992) 'The Voice of the User in Health Care' in Beck, Lonsdale, Newman & Patterson (eds), *In the Best of Health?* London: Chapman and Hall.

Bachrach, P.S. & M.S. Baratz (1963) 'Decisions and non-decisions: an analytical framework' *American Political Science Review*, 57: 641-51.

Barnes, C., Kester, I.H., Painter, C. (1997) *Management in the Public Sector: Challenge and Change* 2nd edition, London: International Thompson Business Press.

Beck, E., S.Lonsdale, S.Newman and D.Patterson (eds)(1992) *In the Best of Health?* Chapman and Hall.

Brown, A.E. & J. Stewart (1993) 'Competing Advocacy Coalitions, Policy Devolution and Airline Deregulation', in Sabatier & Jenkins-Smith, (eds), *Policy Change and Learning: An Advocacy Coalition Approach*, Boulder: Westview Press.

Busfield, J. (1986) *Managing Madness, London:* Hutchison.

Chase, G. (1979) 'A framework for implementing human service programmes: How hard will it be?' *Public Policy*, 27: 387-435.

Clarke, J & J. Newman (1997) *The Managerial State,* London: Sage Publications.

Coats, A.W. & D. Colander (1989) *The Spread of Economic Ideas,* Cambridge: Cambridge University Press.

Cobb, R.W. & Elder, C.D. (1972) *Participation in American Politics: The Dynamics of Agenda-Building,* Baltimore: John Hopkins University Press.

Cohen S (1980) *Folk Devils and Moral Panics*, London: Oxford University Press.

Drucker, P. (1954) *The Practice of Management,* London: Heinemann.

Dunleavy, P. (1981) *The Politics of Mass Housing in Britain: Corporate Power and Professional Influences in the Welfare State,* London: Oxford University Press.

Dunleavy, P. (1991) *Democracy, Bureaucracy and Public Choice: Economic Explanations in Political Science* Hemel Hempstead: Harvester Wheatsheaf.

Dunsire, A. (1978) *Implementation in a Bureaucracy*, Oxford: Martin Robertson.

Dye, T.R. (1976) *What Governments Do, Why they do it, What difference it makes*, Tuscaloosa, Ala.: University of Alabama Press,

Easton, D. (1953) *The Political System,* New York: Alfred A Knopf.

Edelman, M. (1977) *Political Language: Words that Succeed and Policies that Fail,* New York: Institute for the Study of Poverty.

Edwards J. & R. Batley (1978) *The Politics of Positive Discrimination,* London: Tavistock.

Elcock (1990) *Change and Decay? Public Administration in the 1990s,* London: Longman.

Elmore R. (1979) 'Backward mapping' *Political Science Quarterly* 94: 601-16
Friend et al (1974)

Flynn, N. (1990) *Public Sector Management,* Hemel Hempstead: Harvester Wheatsheaf.

Ford, R & J. Kwakwa (1996) 'Rapid reaction: speedy recovery' *Health Services Journal,*18 April: 30-31.

Gardiner (1999) *Partnerships in progress: New ways of working in mental health,* Institute of Health Services Management.

Gill, J. & P. Johnson (1991) *Research Methods for Managers,* Paul Chapman Publishing Ltd

Glaser, B.G. and A.L. Strauss (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research,* New York: Aldine Publishing Company.

Gordon, I., J. Lewis and K. Young (1977) 'Perspectives on policy analysis', *Public Administration Bulletin,* 25: 26-35.

Haas, E.B. (1990) *When Knowledge is Power: Three Models of Change in International Organisations,* California: University of California Press.

Habermas, J. (1976) *Legitimation Crisis,* London: Heinemann.

Hall, P.A. (ed) (1989) *The Political Power of Economic Ideas,* Princeton: Princeton University Press.

Ham, C. & Hill, M. (1993) *The Policy Process in the Modern Capitalist State,* Hemel Hempstead: Harvester Wheatsheaf.

Harrison, S. D.J.Hunter & C.Pollitt (1990) *The Dynamics of British Health Policy* London: Unwin Hyman.

Heclo, H. (1972) 'Review Article: Policy Analysis' *British Journal of Political Science,* 2: 83-108.

Henshel, R.L (1990) *Thinking About Social Problems,* New York: Harcourt Brace Jovanavich.

Hogwood, B.W. & L.A. Gunn (1984) P*olicy Analysis for the Real World,* London: Oxford University Press.

Hood, C.C. (1976) *The Limits of Administration,* London: John Wiley.

Hunter, D. (1992) 'The Move to Community Care with Special Reference to Mental Illness' in Beck, E., S.Lonsdale, S.Newman and D.Patterson (eds)(1992) *In the Best of Health?* London: Chapman and Hall.

Hurford, G. (1992) 'Sunshine and Shade: a comparative review of mental health services in the UK and Spain' *Journal of Mental Health,* Vol. 15.

Hurford, G. (1990) 'How we wrote the strategic plan for mental health services in S Derbyshire' unpublished essay, Aston University.

Jenkins, W.I. (1978) *Policy Analysis: A Political and Organisational Perspective*, London: Martin Robertson.

Jones, J.A. (1971) *Federal Efforts to Solve Contemporary Social problems*, in Smigel, ed, 1971

Jones, K. (1988) *Experience in Mental Health: Community Care and Social Policy*, London: Sage.

Joseph, K. (1973) 'Sir Keith Joseph surveys the NHS: achievements and failures' in the *British Medical Journal* 1 Dec: 561-2.

Kingdon, J.W. (1984) *Agendas, Alternatives and Public Policies,* Boston: Little, Brown.

Klein, R. (1989) *The Politics of the NHS,* London: Longman.

Knapp, M. et al (1990) *Predicting the Community Costs of Closing Psychiatric Hospitals: The TAPS Project,* Canterbury: Personal Social Services Research Unit.

Knapp, M., J. Beecham & P. Cambridge (1992) *Care in the Community?: Challenge and Demonstration*, Aldershot: Avebury Press.

Laffin, M. & K. Young (1990) *Professionalism in Local Government,* London: Longman.

Lawton, A. & A. Rose (1994) *Organisation and Management in the Public Sector* London: Pitman Publishing.

Lasswell, H.D. (1930) *Psychopathology and Politics,* Chicago: University of Chicago Press.

Leff, J. (1997) (ed) *Care in the Community: Illusion or Reality?* Chichester: John Wiley & Sons.

Levin, P. (1997) *Making Social Policy* Buckingham: Open University Press.

Lewis, J. & R. Flynn (1979) 'Implementation of urban and regional planning policies' *Policy and Politics,* 7: 123-42.

Lowndes, V. (1996) 'Change in public service management: New institutions and management regimes', *La Journee D'Etude Local Governance,* Paris.

Lukes S. (1974) *Power: A Radical View,* London: Macmillan.

Majone, G & A. Wildavsky (1978) 'Implementation as evolution' in H. Freeman (ed) *Policy Studies Review Annual,* 1978, Beverly Hills: Sage.

Malin, N. (1994) (ed) *Implementing Community Care,* Buckingham: Open University Press.

May, T. (1997) *Social Research: Issues, Methods and Process,* Buckingham: Open University Press.

McCourt Perring, C. (1992) 'The Experience and Perspectives of Patients and Care Staff in the Transition from Hospital to Community Based Care' in Ramon S.(ed) *Psychiatric Hospitals Closure: Myths and Reality,* London: Chapman & Hall.

Means, R. & R. Smith (1994) *Community Care: Policy and Practice,* London: Macmillan.

Murphy, E. (1990) *After the Asylums – Community Care for People with Mental Illness,* London: Faker & Falser.

Parsons, W. (1995) *Public Policy: An Introduction to the Theory and Practice of Policy Analysi,s* Aldershot: Edward Elgar.

Peck, J.and R. Parker (1998) 'Mental Health in the NHS: Policy and Practice 1979-98.' *Journal of Mental Health;* 7(3): 241-259, June.

Peters, T. and R.H. Waterman (1982) *In Search of Excellence* New York: Harper & Row.

Pettigrew, A. E. Ferlie and L. McKee (1992) *Shaping Strategic Change,* London: Sage Publications.

Pliatsky, L. (1987) in 'The Macro Choice' by A. Gillie et al, *Politics and Economic Policy,* London: Hodder & Stoughton.

Polsby, N. (1963) *Community Power and Political Theory,* New Haven: Yale University Press.

Ramon, S. (1996) *Mental Health in Europe* MIND Publications, London: Macmillan Press.

Rogers, A. and D. Pilgrim (1996) *Mental Health Policy in Britain* London: Macmillan.

Sabatier, P.A. (1987) 'Knowledge, policy-orientated learning and policy change', *Knowledge: Creation, Diffusion, Utilization*, 8: 649-92

Schattschneider, E.E. (1960) *The Semisovereign People,* New York: Holt, Rinehart & Winston.

Sheppard, M. (1991) *Mental Health Work in the Community: Theory and Practice in Social Work and Community Psychiatric Nursing,* London: The Falmer Press.

Silverman, D. (1993) *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*, London: Sage Ltd.

Simon, H.A. (1957) *Models of Man: Social and Rational*, New York: John Wiley.

Smith, D. and G. May, (1980) 'The artificial debate between rationalist and incrementalist models of decision making', *Policy and Politics*, 8: 147-61.

Strauss, A. (1978) *Negotiations,* San Francisco: Jossey Bass.

Turner, T. (1997) 'The Future of Community Mental Health in a Community Setting', in Spiers, J. (ed) *Dilemmas in Modern Health Care.* Social Market Foundation Paper No 33, November.

Wilding, P. (1982) *Professional Power and Social Welfare* London: Routledge and Kegan Paul.

Wolfensberger, W. (1972) *The Principle of Normalisation in Human Services*, Toronto: National Institute of Mental Retardation.

Appendix A

Questions for Social Services staff (retrospective)

1 How involved have you been in planning and delivering mental health services?
2 How has this changed over the last *n* years?
3 What advantages have you found in joint working with the NHS ? (Potential and actual)
4 What barriers did you find in joint working?
5 Where did you go for support and advice?
6 How has the internal market affected relationships?
7 At what level of the organisation do you think SS managers can make the most impact?
8 How do you distinguish between health and social need?
9 Has the new Labour Government affected the planning or delivery of mental health services in your area?
8 What makes the most impact, people or policies?

Questions for NHS Staff (Macro)

1 Please could you outline your organisational structure?
2 How would you personally define planning?
3 How would you describe your relationships with ministers?
4 At what level of the organisation do you think strategy is formed?
5 Is planning effective at the national level?.. have you encountered any barriers?
6 Can you give me an idea of the sort of pressure groups that influence the decision making process at national level? What is the range and how is access determined?
7 What areas of discretion do you think are available to local managers?
8 Do you think managers' own values affect the decision making process at national level?

Questions for Voluntary sector (Macro level)

1 What geographical areas does your organisation cover and what is its core business?
2 Can you tell me about your own role?
3 Can you describe your organisation's relationships with the various bodies?
4 How much discretion do you feel your organisation has in implementing government policy?
5 Do you think managers' values in the vol sector affect the decision making process?

Appendix A (contnd)

Questions for NHS staff (Meso level)

1 Please could you explain your organisational structure and where you fit in this?
2 How would you describe relationships with the executive and the regional outpost?
3 How would you describe your relationships with the providers?
4 How would you define planning?
5 What are the barriers/ problems you experience in planning at district level?
6 Can you give me an idea of the sort of pressure groups that influence the decision making process at provider level? What is the range and how is access determined?
7 What areas of discretion do you think are available to provider managers who implement policy?
8 Do you think managers' own values affect the decision making process?

Questions for voluntary sector staff (Meso level)

1 Can you tell me about the background and structure of your organisation?
2 Can you tell me about your own role and responsibilities?
3 Can you tell me about your organisations' relationships with other bodies?
4 Are there any areas where you feel your organisation has discretion in shaping or changing government policy?
5 Is policy ever formulated at dha level?
6 Do you think managers' own values affect the decision making process?
7 Who controls resources?

Questions for NHS staff (Micro level) PROV 1,2 (retrospective)

1 How much choice did you have about the move to community care?
2 What barriers did you encounter?
3 What advantages did you feel you had?
4 How much discretion did you feel you had in implementing policy?
5 What other agencies did you work with?
6 At what level do you think managers can make the most impact?
7 Do you think managers' own values affect the decision making process?
9 What makes the most impact, people or policies?
10 What were the highs and lows of your career?

Questions for NHS staff (Micro level) PROV 3,4 (current)

1 Can you tell me about your core services?
2 How would you define planning?
3 How much discretion do you feel you have in implementing policy?
4 Can you tell me about the pressure groups that affect your organisation?
5 Do you think managers' own values affect the decision making process?
6 What are the constraints and strengths for your unit, when implementing policy?

Appendix B
Decision making questionnaire

DECISION-MAKING EXERCISE

This exercise is designed to develop an understanding of the different approaches to decision making within society and within organisations.
Read the statements below quickly and register an immediate response. You have a choice of five responses:

(a) I strongly agree with this.
(b) In general I agree with this.
(c) I am unsure.
(d) In general terms I disagree with this.
(e) I strongly disagree with this.

Responses

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

1 At one time decisions are made in one way but at other times in a different way. It all depends upon the issue.
2 In order to understand how decisions are made it is necessary to recognise that the power of the organisation is divided between a number of different groups and individuals.
3 The decision-making process in your organisation is dominated by a small group of individuals with little access to this group for anybody else.
4 Your boss consults you on all decisions.
5 Your boss never consults you on any decision.
6 You feel like a small cog in a large machine.
7 Civil service mandarins really run the country.
8 In local government chief officers have all the power.
9 Power in Britain is in the hands of the people.
10 Those with positions of authority within organisations should make all the decisions.
11 Decision making in your organisation is made by a few cronies behind closed doors.
12 The decisions made in your organisation are the result of careful deliberation of all the issues and involvement of all the people that have an interest in the issue.
13 Central government always decides.
14 The elected representatives of the people should make decisions.
15 It should be experts that make all the decisions in public sector organisations.

16 There should be more discretion in your organisation.

Source: Lawton, A & A Rose (1994) *Organisation and Management in the Public Sector* (Appendix B) Pitman Publishing

Appendix C
Rules and decision-making questionnaire

BUREAUCRACY EXERCISE

Consider each of the following scales. Indicate on the scale (where 1 = very closely and 5 = not at all closely) how closely your organisation approximates to the end of each scale.

formal rules	1	2	3	4	5	informal rules
job description	1	2	3	4	5	unspecified duties
written communication	1	2	3	4	5	oral communication
specialised functions	1	2	3	4	5	workersare generalists
clear hierarchy	1	2	3	4	5	fluid organ form
criteria for promotion	1	2	3	4	5	no criteria
permanent appointments	1	2	3	4	5	temporary appts

Source: Lawton, A & A Rose (1994) *Organisation and Management in the Public Sector* (Appendix B) Pitman Publishing

Appendix D
RAPS Survey

RESOURCE ALLOCATION PREFERENCES SURVEY

(RAPS 2)

RAPS is an instrument designed to identify your personal values about the ways in which resources in mental health services should be allocated.

INSTRUCTIONS

Please read each of the following statements and rate them according to its relevance to your values, beliefs and actions in your job. Please use the following rating scale:

1 = this statement expresses my preferences very well
5 = this statement does not express my preferences at all

The figures 2 3 and 4 can be used to show intermediate points between the two extremes of 1 and 5.

1 STATEMENTS	2 RATING SCORE
1) Mental health resources and services should be allocated according to careful, expert and objective assessment of individuals' needs.	
2) If people have to be made redundant the fairest way of choosing who is to go is by drawing lots.	
3) The reality of resource allocation means treating interest groups, pressure groups and lobbies as an important part of the process and not as an irritation and distraction.	
4) The willingness of clients to co-operate in the provision of mental health services should affect the services they receive. The un-co-operative should receive less than the co-operative.	
5) Resource allocation should involve measurement of output and the economic evaluation of professional activities and services.	
6) Interest groups who take the trouble to inform themselves about the organisation's services should have an important contribution to the planning and delivery of services.	
7) If budgets must be cut, then all budgets should be cut by the same percentage.	
8) The provision of mental health services should be standardised and allocated by formal rules applied equally to all clients.	
9) If we have to make people redundant we should retain those whose lives would be most disrupted by redundancy.	
10) If budget cuts have to be made, then those departments and services which make the least contribution to the organisation's objectives should bear the brunt of the cuts.	

11) People are morally responsible for their actions and so moral judgements about clients are an important factor in allocating mental health services.

12) When resources are limited staff should be constantly vigilant for people trying to cheat the system and abuse services.

13) Sometimes we have to provide mental health services to meet individual needs even if it is not cost effective to do so.

14) When making people redundant, criteria must be used which are acceptable to management, unions and any other powerful interested group involved.

15) The goal of resource allocation should be equality of access and opportunity for mental health users.

16) Mental health resource allocation is deeply involved with the mobilisation of support in an area, and with satisfying particular interest groups.

17) In hard times mental health services should concentrate on responding positively to groups in the community who are trying to help themselves.

18) It makes good sense to put mental health resources where they can do the most good, and not necessarily where they are most needed as long as nobody is made worse off than they already are.

19) When redundancies are inevitable it should be those who make least contributions to the organisation's objectives who should go.

20) The focus in mental health service provision should be on the individual client and the need to do everything possible to help her or him. All services that have some chance of doing some good should be provided.

People have preferences about the criteria to be used in resource allocation whether they are involved in the decision making, involved in the implementation or on the receiving end of the policies. These different criteria or heuristics can be classified under the following six headings.

1. The Deservingness heuristic — This divides resources between groups and individuals according to the resource provider's classification of them as either deserving or undeserving. This is a moral judgement. Groups or individuals who are thought to have created their own problem or to be demanding and difficult are often labeled undeserving.

2. The Individual need heuristic — This heuristic responds to individual needs. It is not concerned with the overview of a service but with meeting the needs of individuals. Needs are identified and ranked in importance by using professional judgement. It does not make moral judgements about the individuals.

3. The Fairness heuristic — This heuristic is more concerned with treating all clients fairly than with the provision of services to individuals. Fairness is about standardisation and equal access to services by all clients. Its aim is to avoid accusations of unfairness. Fairness can be planned or created by arbitrary means (such as queues in which all have equal probability of receiving service irrespective of their background and situation).

4. The Utility heuristic — This is concerned with maximisation of output, that is to say with efficiency and effectiveness. It deals with the notion of the common good rather than individual need. Generating the greatest amount of 'good' is more important than the way it is distributed amongst the community.

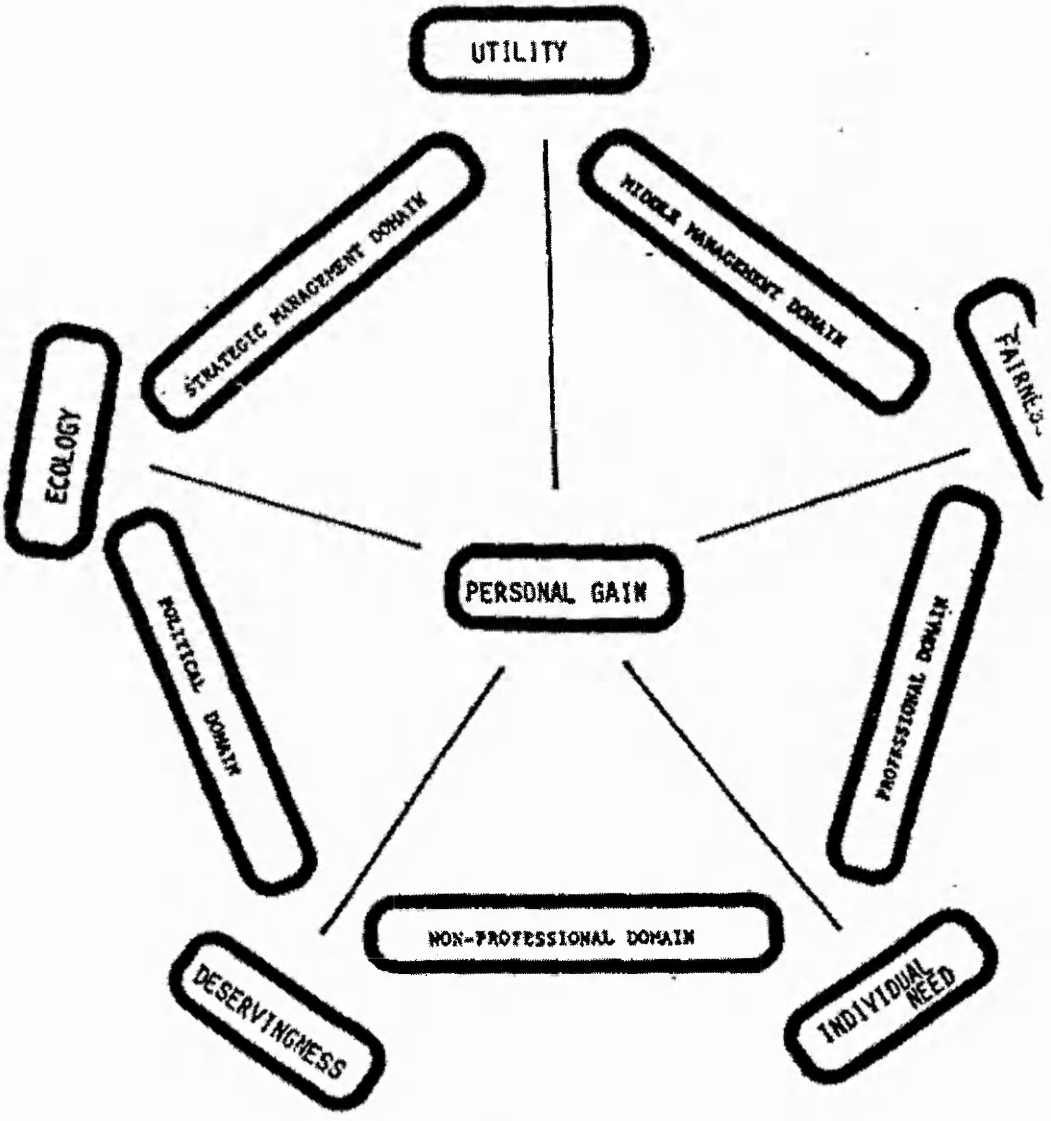
5. The Ecology heuristic — This heuristic allocates resources by taking into account the demands of the various

	interest groups involved with the service. The greatest weight will be given to the most significant or powerful groups. The success of the allocation is measured by the extent if meets the needs of these groups, not according to objective or professional criteria.
6. The Personal gain heuristic	In this case resources are allocated in a way that will create personal gain for the staff involved. In extreme cases, this gain could be financial, but more often it will be a gain in power, job satisfaction, working condition, or the achievement of a personal objective.

It is suggested that, with the exception of personal gain which is potentially relevant to everyone, the heuristics which people prefer are associated with their role or 'domain' in the organisation.

The following figure provides a model of the relationship between heuristics and domains

THE VALUE HEURISTICS OF
RESOURCE ALLOCATION



Mark the heuristics that you responded to.

Appendix E
Psychiatric bed rates, UK (Ramon, 1996)