

**A Genealogy of the Care Programme Approach
in Mental Health Services**

**A thesis submitted in partial fulfillment of the requirements of the
University of East London for the Doctoral Degree in Clinical Psychology.**

May 2013

ABSTRACT

The Care Programme Approach (CPA) was introduced by the Government in 1991 as an administrative strategy for community mental health services involving; assessment, planning, care co-ordinators and regular reviews. The study applied a genealogical methodology to conduct a historical analysis of the CPA from 1945 to the present day. This explored the political conditions of possibility for its emergence in 1991 and its evolution. The constructions of mental health and mental health services represented by the CPA were considered and how they have changed over time. The CPA might reflect wider themes in the mental health system such as, the dominance of the New Public Management in mental health services since the 1980s, and a concern with risk management since the 1990s. Implications for policy and practice are discussed.

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CHAPTER 1: INTRODUCTION

1.1 Introduction

The idea for this study came from an announcement I heard during a community mental health team meeting when I was on placement in the first year of training for the professional doctorate in clinical psychology. The team was informed by the manager that patient care plans were from now on to be written in the first person singular. The team members were provided with an information sheet, which contained the following statement:

“Using the first person singular forces us to think about the care plan from the service user perspective. As care plans should be written in collaboration with the service user, it is a means of writing it from their point of view”.

As a trainee clinical psychologist on a course informed by critical ideas I was drawn to some of the questions that this announcement provoked such as: How is mental health care thought about? How are mental health services organised? How has this changed over time? I was also sensitive to the fact that many of the patients the team were involved with came within the Mental Health Act, 1983.

In light of the questions this announcement raised, I wondered whether dominant ideas about mental health and mental health services could be represented by this statement; and whether a study of the care plan document and the Care Programme Approach (CPA) might bring to light some themes that resonate more widely within the mental health system. This idea was initially informed by Harold Garfinkel’s major work “Studies in Ethnomethodology” (1967), which emphasises a “bottom up” perspective, with the focus on everyday practices which contribute to the production of social order. Also I related it, to the hologram metaphor used by the American physicist David Bohm (1980) to consider how information about a whole system can be encapsulated by a single structure, which represents the whole.

1.1.1 Overview of the Chapter

This introductory chapter will start by providing a definition of the CPA. It will then proceed to provide a brief rationale for the study, a review of the literature, the methodology, and the presentation of the research questions. There was some dilemma in the ordering of this chapter, as the methodology does not require the separation of “method”, and “introduction”, as they are regarded as interlinked, one informs the other, so the separation is somewhat artificial. However, it was felt that the initial investigation of the literature to some extent informed the chosen method and this is why the chapter has been arranged in this way.

1.1.3 The Care Programme Approach

The care plan forms one of the central components of the CPA, which was introduced by the Department of Health Circular in 1990, and formally launched in England in April 1991 (Department of Health, 1990). The CPA is the method of organising the management of psychiatric patients both while in hospital and in the community. Initially it was only conceived for in-patients at the point of discharge, and for new referrals in specialist services. However it was extended to include all those in contact with services (DH, 1993). It was introduced at a time when the closure of large Victorian mental hospitals had accelerated (from the late 1980s), and there was a growing concern how recently discharged patients would live in the community, the potential risk they posed to the general public, and the ability for the newly establishing community services to manage them (D. Rose, 1998). Commentators have reflected on a contradiction at the heart of the CPA: between providing care to the patient on the one hand, and controlling their behaviour on the other (Rose, 1998).

The four main components of the CPA were described in the Joint Health and Social Services Circular (DH, 1990a):

- Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
- The formation of a care plan which identifies the health and social care

required from a variety of providers;

- The appointment of a key worker to keep in close touch with the service user and to monitor and co-ordinate care; and
- Regular review and, where necessary, agreed changes to the care plan.

From its origins there is no clear account of the development of CPA documentation, and no standardised documentation, meaning that the format of the form varies from the different regions of the country (The Sainsbury Centre for Mental Health [SCMH], 2005). There have been numerous changes to the appearance of the CPA form, the consequences of which will be discussed in Chapter 4, and an example of a 2004 form can be found in Appendix A. The form generally includes an assessment of the patient's needs, a plan to meet those needs, a contingency/crisis plan, and the needs of the patient's carer/relatives. Also it should demonstrate that the patient has been involved in making the plan and it will be signed by them to say they have been given a written copy (SCMH, 2005).

In summary, the CPA involves; assessments, care planning, allocation of a key worker and regular reviews. It was introduced by the Government in 1991, in the wider context of de-institutionalisation and the resulting concerns as to how patients would be managed outside the asylum. Before proceeding with a discussion of some of the literature related to the CPA it is important to return again to why a study of the CPA and an historical approach might be useful.

1.1.4 A Rationale for the Study

The introduction of the CPA might reflect wider changes in the way in which mental health was viewed, and the role of mental health services are constructed. For example, in recent years there has been a growing interest in "user-involvement" and shared decision-making in mental health services (Torey and Drake, 2010). At the same time, there has been an increasing emphasis in the law on the deprivation of liberty. For example, the Mental Health Act 2007 (which

amends the Mental Health Act 1983) introduced Supervision Community Treatment, including Community Treatment Orders (CTOs).

“There remains a political and cultural tension in delivering a traditional government provided mental health service whilst simultaneously championing the role of the individual and their care co-ordinator as broker of how care is delivered and money is spent”

(Goodwin and Lawton-Smith, 2010, p.8).

An historical investigation of the CPA might allow for an exploration of how mental health and mental health services are approached and how this has changed over time. It might also create the opportunity for some careful analysis of how mental health and the role of the professional has changed over the years. An investigation of the past in this context may encourage some different thinking around present concerns, to open some space to understand and to question dominant modes of thinking about mental health.

1.1.5 Strategy for Searching for Material

This study required access to a variety of material related to the CPA. The search strategy involved some systematic searching of academic electronic databases (PsychInfo, PsycArticles), and the internet search engine Google Scholar. Initial terms included combinations of three main groups (1) Care Programme Approach; Care Plan; CPA; Case Management. (2) Mental Health; Mental Illness; Psychology; and Psychiatry. (3) Deinstitutionalisation; and Community Care. (4) Public Management; and Risk. A separate search for historical materials was conducted using the search engines Google, Google scholar, and Google books. After reading abstracts, the most relevant references were obtained and are cited.

1.2 A Literature Review of the CPA

The next section is a review of the literature related to the CPA. Some of the points here will be developed further in Chapter 4. This section contains less theoretical analysis, rather its intention is to provide a review of some relevant literature to the CPA to inform the inception of the study. The following criteria were applied when assessing relevance of the literature: official government literature related to the CPA; professional/academic research; and service user led research. These criteria were considered to be more relevant than other material (e.g. interviews with professionals) as they represent official statements of Government policy and mental health research. This connects to the idea that the CPA might represent a microcosm of mental health services and the way they have been constructed (see section 1.3.1, p. 22). The literature review has been organised into three sections: Section one will involve literature related to the CPA and its relationship to the Mental Health Act 1983, and Government policy. Section two will involve literature related to the CPA and its relationship to notions of shared care planning and user involvement. Section three will involve literature related to the evaluation of the CPA. Table 1 provides a summary of the key changes to the CPA.

1.2.1 The CPA and Government Policy

This section will discuss the evolution of the CPA in relation to Government policy and the law. As has already been established, the CPA involves a process where patients are assessed, allocated to a level of care, documented in the form of a care plan and monitored regularly (DH, 1990a). Commentators have remarked that the CPA established a rationalised process which would integrate ideas of care and control (Rose, 1998).

The CPA has been influenced by changes to the Mental Health Act 1983 which will now be discussed. The Mental Health (Patients in the Community) Act 1995, made the CPA a statutory requirement for all services, and introduced supervised discharge for some patients (H.M. Government, 1995) (see Table 1). This meant that after being discharged into the community patients would have certain conditions such as medication compliance. Sectioning represents an experience

in health and social care with serious consequences; there are few other situations (other than perhaps the containment of infectious diseases) where a person is held against their will and forced to comply with a treatment regime. There may be some instances therefore where a patient's care plan is predominantly written from a service perspective as required by the Mental Health Act 1983. According to the Mental Health (Patients in the Community) Act 1995, those who are under supervised discharge:

“will have been assessed as presenting a substantial risk of serious harm to themselves or other people, or of being seriously exploited if they do not receive suitable after care”

(H.M. Government, 1995, p.2).

Table 1 The Evolution of the CPA 1990-2012

1990	CPA guidance issued: The Care Programme Approach (DH, 1990).
1991	CPA Introduced: assessment, care plan, keyworker, and regular reviews.
1993	Code of practice to the Mental Health Act 1983, establishes that the CPA applies to all patients seen at specialist psychiatric services.
1993	An evaluation of CPA conducted by the Department of Health reports problems in the implementation of the CPA and resistance from staff (North et al, 1993).
1994	The Audit Commission reports on failure of services to implement the CPA.
1995	The Department of Health proposes a tiered approach to CPA (some services use three levels: 1,2,3, some use two levels). (DH, 1995).
1995	<i>CPA becomes statutory</i> : Mental Health (Patients in the Community) Act 1995 (it also introduces Supervision Registers).
1999	National Service Framework for Mental Health: Patients to have a written copy of the CPA and for it to include a crisis plan.
1999	Code of practice to the Mental Health Act, 1983 reiterates importance of CPA for all patients and its key elements.
1999	Levels of CPA simplified to “Standard” and “Enhanced” and CPA to be integrated with Care Management. CPA now used by both health and social care staff in all settings. (NHSE, & SSI, 1999).
2003	Plans to abolish Supervision Registers depend on Trusts establishing a “robust CPA” (CPAA, 2003).
2004	Mental Health Minimum Data Set launched: shows 66 per cent of patients do not have a CPA (see Figure 1, p. 71).
2008	Removal of “standard levels” of CPA; the “(new)CPA” CPA is introduced only for high risk patients. (DH, 2008).
2012	Some NHS Trusts introduce writing care plans in the first person singular, and the introduction of recovery goals (London Strategic Health Authority, 2010).

The Mental Health Act Code of Practice (DH, 1993) clarified that the CPA applied to all those receiving mental health services including in-patients. In 1995 levels to the CPA were introduced which suggested a shift towards a definition of the “severely” mentally ill which the CPA, with its full multidisciplinary approach was best suited for (DH, 1995) (see Table 1). This followed in the wake of “The Report of the Inquiry into the Care and Treatment of Christopher Clunis” which allocated blame to a failing community care system (Ritchie & Lingham, 1994). In 1999 the Department of Health issued a document entitled; “Modernising the Care Programme Approach ” (NHS Executive & Social Services Inspectorate, 1999). Here the levels of CPA were simplified to “standard” and “enhanced” to replace Supervision Registers, and key workers were replaced by “care co-ordinators” (see Table 1). This again placed an emphasis on identifying the most in need, or the highest risk patients:

“The development of a system where the enhanced level of the CPA identifies and ensures the provision of services to meet the needs of the most vulnerable users means that there no longer remains a need for Supervision Registers.”

(NHS Executive & Social Services Inspectorate [NHSSSI], 1999 p 17).

The “enhanced CPA” was for those who are considered to need inter-agency co-ordination, to require more intensive interventions, to be at risk of harming themselves or others, and to be more likely to disengage from services. The establishment and development of CPA “levels” might suggest that the CPA was taking on more of a surveillance role.

The national service frameworks (NSF) were established in 1999 across NHS sectors to provide appropriate guidelines and protocols for running services (See Table 1). Standard Four of the NSF for mental health (DH, 1999a p. 10) directed that all patients on CPA should:

“Receive care which optimises engagement, anticipates or prevents a crisis, and reduces risk, and have a copy of a written care plan which:

- Includes the action to be taken in a crisis by the service user, their carer, and their care co-ordinator;
- Advises their GP how they should respond if the service user needs additional help;
- Is regularly reviewed by their care co-ordinator;
- Be able to access services 24 hours a day, 365 days a year”.

(DH, 1999a p.10).

The CPA provides an organisational framework for the monitoring and control of psychiatric patients in the community. This logic (i.e. the need for control) was followed through with the Mental Health Act 2007, which as mentioned above, amended the Mental Health Act 1983 to introduce Supervision Community Treatment, including Community Treatment Orders. This power replaced supervised discharge, with the authority to return the patient to hospital, where the patient may be forcibly medicated if they are not compliant with their medication in the community. In 2008 the Department of Health issued further guidance: “Refocusing the Care Programme Approach” which abolished the standard CPA (DH, 2008) (see Table 1). This meant that the CPA (now called the “(new)CPA”) was only for those who were reluctant to engage in services, were deemed to be high-risk and required inter-agency co-ordination. The implications for this will be discussed in Chapter four.

So far, this section has described how the CPA has evolved in relation to Government policy priorities and changes in the Mental Health Act, the discussion will continue to reflect on how the CPA has been influenced by policy. The study is interested in how the CPA might reflect ways in which mental health services have changed over the years. Governments over the years have contributed greatly to the way in which mental health services are constructed. This can be demonstrated by the exponential increase in legislation and guidance related to mental health services since the 1980s (Boardman, 2005). Conducting a brief search of the Department of Health website (www.dh.gov.uk) under

“mental health” over 90 official documents related to mental health policy in England were found in the three years between 2010-2013.

One of the ways in which Government has tried to shape mental health services using the CPA can be seen with the agenda to promote inter-agency working (Powell, 2008). This section will first describe the problem of inter-agency working, before discussing how the CPA was utilised as a possible solution. Problems with inter-agency working were in part created by conflicting policies related to community care. In the same year that the CPA was introduced the Government passed the NHS and Community Care Act (DH, 1990b). This was a huge reorganisation of both the NHS and Social Services that included the introduction of the internal market and the establishment of NHS Trusts (Simpson et al, 2003). This meant that in Local Authority Social Services, social workers assessed social needs, designed ‘packages of care’ and purchased services from medical providers such as the NHS, but also from charities and private companies (DH, 1990b). Professionals in social services were struggling to work under this new system, described as “Care Management”. And at the same time their colleagues in health services were struggling to work with the new CPA system (Allen, 2004).

A study commissioned by the Department of Health found that there was a lack of joint working from staff during this early phase of introduction (North & Ritchie, 1993). The lack of “joined up working” was described as a failure of the community care system to prevent homicides by psychiatric patients (Ritchie and Lingham, 1994). A guidance document from the Department of Health in 1995 provided guidance on inter-agency working (DH, 1995). The theme of co-operation was continued with “Modernising the Care Programme Approach” (NHSSSI, 1999) and required that the CPA in the NHS and the Care Management system (used by Local Authority Social Services) be integrated. However, these attempts to improve partnership working and co-ordination of care at a structural level did not increase “service user” involvement in the care planning process (Rose, 2003). This section has discussed how the CPA is connected to Government policy priorities such as the “joined up working

agenda”. The next section will discuss the provision of care and the collaboration with the patient in care planning.

1.2.2 The CPA, Case Management and Shared-Care Planning

The CPA was based on an approach developed in North American mental health services in the 1970s known as “Case Management” which was developed in response to the closure of the large psychiatric hospitals (Sainsbury Centre for Mental Health [SCMH], 2005). As discussed the NHS and Community Care Act 1990 issued the Care Management system (DH, 1990b) which operated until it was integrated with the CPA (NHSE & SSI, 1999) (see Table 1). The Care Management system was initially part of a brokerage model whereby professionals arranged for the provision of services without the need for direct contact with the patient (Mueser et al., 1998). This brokerage model evolved into one that incorporated the “therapeutic relationship” and new models such as “assertive community teams” were introduced (Stein and Test, 1980). The CPA can be thought of as a variant of Case Management, although it is not based on a specific model; with critics claiming that it serves more of a bureaucratic than a therapeutic function (Simpson et al., 2005b).

Shared care-planning, derived from general health care settings, is based on the idea that the patient has information about different treatment options and makes an autonomous choice on which option best meets their needs (Elwyn, 2005). Diana Rose (2003) has evaluated how services have implemented shared care planning with the CPA, from the point of view of the patient, and has indicated that there is significant dissatisfaction. For example, patients have not been involved in the care planning process, and have not been provided with a written care plan (D. Rose, 2003). Research suggests that there is dissatisfaction with the explanations provided for mental distress, especially from those with black and minority ethnicity. There also seem to be examples of where service users disagree with their treatment regime, but professionals have been bound by statute to administer it to them (Gould, 2012). Commentators have questioned how the CPA (said to be based on a shared-care approach) can simultaneously

respond to the pressures represented by the Mental Health Act 2007, and its focus on risk and public safety. For example Trivedi (2010) has raised this specific issue in relation to the disproportionate number of black and minority ethnic communities in compulsory services.

The Department of Health's 2008 publication "Refocusing the Care Programme Approach" endorses the use of shared-care planning:

"What is clear is the importance of open discussions on values and principles between individuals and professionals" and "service users will only be engaged if the care planning process is meaningful to them".

(DH, 2008 p 6-8).

1.2.3 The Care Plan Documentation

In 2003 the CPA Association stated that there was no standardised documentation for the CPA, and it is somewhat unclear how the forms are developed and/or whether patients are involved in this process. From origins in the early 1990s there does not seem to be any clear account of the development of CPA documentation (Sainsbury Centre for Mental Health [SCMH], 2005). An example of a CPA form (extracted from Allen, 2004) can be found in Appendix 1. The SCMH (2005) have outlined a comprehensive care plan:

"Include an assessment of all the service users' needs, including: mental health; physical health; daily living skills; housing; daytime activities; social and family relationships; risk behaviour; disability; communication; dietary needs; and needs associated with gender, sexuality, ethnicity and spirituality.

Specify plans to meet all the identified needs, including the identified interventions and expected outcomes.

Include a contingency plan, specifying action to be taken to prevent a crisis

developing, and a crisis plan.

Indicate that the service user has been involved in drawing up the care plan, and will be signed by them to say they have been given a written copy.

Say who else was involved in drawing up the care plan, and who has been given a copy of it.

Record the date of the next CPA review meeting.

Record that the needs of carers and family members were assessed and planned for”.

(Sainsbury Centre for Mental Health, 2005, p. 4).

Howells and Thompson (2002) have described the production of eCPA, which was an attempt at creating an electronic, standardised CPA that claimed to be able to improve the quality of information acquired and service delivery. Kingdon and Amanullah (2005) reflecting on their experience of using the CPA in practice commented: “the form expanded from two sides of A4 to a pack of more than an inch thick...(this was) derided and erratically used by staff but given 5-star rating by the Commission for Health Improvement” (Kingdon and Amanullah 2005 p. 327). This section has outlined what the CPA document involves, and how this has been subject to change. The next section will provide a review of the literature that has evaluated the CPA.

1.2.4 Research Evaluating the CPA

Evaluative research of the CPA has primarily been focused on evaluating its effect on mental health services, for example on reducing the rate of hospital admissions or whether it improves relapse prevention. There seems to be less evaluation of the content of the document, or what its assumptions are. This gap in the literature provides some justification for a study of this kind, to carefully consider the assumptions behind the CPA.

An early review of the CPA following its introduction in England, commissioned by the Department of Health (North and Ritchie, 1993), suggested that it was merely a formalised version of existing systems of good practice, such as shared assessments and care planning. However it has been suggested that where patients are involved in their care, more positive feedback is gained from the patient (Beeforth et al, 1994). Also some patients have said that they value having a written care plan as this might protect some of their rights such as allocation of disability benefits. Practical help with issues such as housing and finance were also reported as having a positive effect, as well as support with leisure and social activities (Beeforth et al., 1994).

Perkins and Fisher (1996) examined CPA care plans in a London NHS Trust. They argued that in addition to the care plan simply being recorded as a marker of service quality, it was important that its content was meaningful to the patient. They assessed how well the care plan reflected the difficulties and strengths as defined by the patient as well as the professional. They reported that the care plans were not always based on what the patient had said in the assessment but were influenced more heavily by professional-defined problems. Kessler and Dopson (1998) explored the implementation of the CPA in relation to the broader political context. They reported on the tensions between the aspirations of central government to drive through rapid changes and the devolved/local management structures who might not see the value in centralised directives (e.g. overly bureaucratic and less helpful for the patient).

The SCMHS User Focused Monitoring (UFM) Project was developed to explore patients' knowledge and experience of CMHTs in London. Less than two thirds of participants knew they had a key worker; a third knew they had a care plan; but only a fifth said that they had been involved in writing it (Rose et al, 1998). Some participants had heard that the CPA would be reviewed at some point, but none thought that they would be involved in the review. Only one third felt their strengths had been taken into account. McDermott (1998) explored the attitudes and experiences of 103 patients in an outer London borough, he found that 50 per cent of the patients found the CPA process difficult to understand.

Anthony and Crawford (2000) conducted a small qualitative study exploring nurses' perspectives on including patients in the care planning process. The study revealed that shared care planning is influenced by: a lack of time, staff shortages and negative attitudes from professionals. They found that professionals valued including patients in the process but that it was challenging to balance their responsibilities in relation to the Mental Health Act with the more person-centred approaches that were beginning to take precedence in their services.

Simpson et al (2003a) conducted a literature review comparing CPA with case management models. They suggest that while the CPA resembles some models of case management, it is ultimately inferior as it does not explicitly include the role of the therapeutic relationship in the process. They point to research that has demonstrated the importance of "manager-client relationship" on positive outcomes. However, the CPA does not include the "therapeutic role" in the care co-ordinator's core functions. Instead, there is an emphasis on the more business-like functions of "monitoring" and "co-ordination". They suggest that not labeling CPA as "Case Management" may have been a lost opportunity; such a move might have increased motivation in professionals by valuing and validating a therapeutic role in the CPA. This study seems to be more concerned with the process of the CPA as opposed to what it contains, and how the CPA constructs mental health. Further research from Simpson et al (2003b) suggested several reasons for their perceived failure of the CPA such as: under-funding of community services; the rise of top-down management strategies (e.g. standards, and targets); disillusioned front-line staff; and poorly functioning community teams.

A report from the UFM project "User's Voices" (Rose, 2001), looking at the perspectives of mental health service users on community and hospital care, found that a majority of users in all sites did not know what the CPA is for. This suggests that the care delivery process may not have been explained to these patients effectively. With the exception of site two they did not know who their CPA keyworker was, and few were able to confirm that they had a written copy of the care plan: "if the care delivery process is not transparent, users cannot know

what to expect from that process or what choices are open to them” (Rose, 2001 p. 50). Following this research Rose (2001) expresses concern that if the CPA situation remains as it is, then it will only serve its bureaucratic role rather than its role to deliver a high standard level of care (Rose, 2001). This might be due to the fact that professionals don’t explain it because they do not see its value or relevance. However if that is the case, it is a one sided decision.

O’Flynn and Craig (2001) discussed how high unemployment figures amongst the CPA population were attributed to social factors (discrimination and stigma, organisational policies, and the regulation of the benefits system) as much as they are due to “personal” factors attributed to mental health problems, and suggests that the CPA could be integrated with a mental health work programme to help patients into work. Carpenter (2004) reported positive findings from interviews of 262 patients with severe mental health problems across four districts in the north of England. The majority of patients felt involved in the planning of their care, had a written care plan, and felt that it helped them becoming independent.

Healthcare commissioners use evidence of how well the CPA is carried out, as one of many performance indicators to measure the “quality” of a service. The Care Quality Commission is now responsible for the evaluation of mental health services and conducts a programme of national mental health patient surveys. The survey includes several items on the CPA: whether the patient has a CPA; whether they understand it; whether they have got a written copy; whether their views were taken into account; whether it set out their goals; whether a crisis plan had been formulated; and whether they have regular reviews. The 2012 survey involved 61 NHS Trusts in England, with responses from 15,000 patients over the age of 18 (CQC, 2012). It found that 13 per cent of respondents on CPA said that they do not have one, 25 per cent of participants on CPA had not been offered a copy of their care plan. Most respondents said that their plan covers what they should do in a crisis. Twenty-four per cent of respondents said that they had not had a care review in the last 12 months. Almost half of survey respondents said that they had not had a review in the last 12 months.

In a recent study Dorothy Gould (2012) has explored “experiences of recovery under the 2008 Care Programme Approach”. This involved 82 participants completing questionnaires and 22 participants in focus groups. Several issues were raised. Participants were concerned that their view of recovery was often different from the professionals’ view. There was a danger that “recovery” was being reinterpreted in a “medical sense” – 89 per cent of participants said that it was important for professionals to acknowledge other ways of explaining their difficulties than psychiatric diagnosis. Some felt that professionals do not take account of this diversity in views. In particular participants from ethnic minority communities said that their descriptions of recovery did not fit those most commonly used in services. As one participant remarked:

“Some service users I’ve spoken to, they don’t want to go to CPA meetings and some of them even said to me: ‘it’s not for us, it’s for the health professional, because they’re going to do what they want to anyway”.

(Gould, 2012, p. 53).

One issue raised was an over-emphasis on risk management from professionals, and a concern about the coercive aspects of the Mental Health Act 2007. Participants reported the negative impact which compulsory treatment had had on their recovery under the CPA, provoking feelings of stigmatisation for example;

“being sectioned was a frightening, humiliating and isolating experience for me...I left hospital very traumatised and ashamed and lacking in confidence. This experience was a completely negative one and hindered my recovery”.

(Gould, 2012, p. 49).

Participants reported that the coercive aspects of the Mental Health Act 2007 were contradictory to the rights-based ethics which are central to most common definitions of recovery.

In summary the literature review has presented information on the CPA in relation to Government policy, Care Planning, shared-care. It has presented literature which has evaluated the CPA from both a professional and patient perspective. The next section will discuss the methodology and why it was chosen for this study.

1.3 Methodology

Genealogy as a methodology was used by the French historian and philosopher Michael Foucault (1926-84). Foucault's genealogical analyses began with an examination of modern power relations in his works: *Discipline and Punish* (1977a). Genealogy owes a certain debt to Nietzsche's "Genealogy of Morals" (1865) as a central hypothesis of the approach derives from a Nietzschean explanation of phenomena in terms of "will to power"- that is knowledge and power are inextricably linked (Hoy, 1989).

Following the logic that information about the mental health system could be represented in the CPA; a historical, genealogical methodology was considered. In particular, this resonated with genealogy, whereby analysis starts from a micro-level to reveal certain wider patterns. This begins with a study of techniques or procedures such as the CPA, at the most basic level and documenting their change over time.

"To understand the modern forms of rule, we suggest requires an investigation not merely of grand political schemata...but of apparently humble and mundane mechanisms which make it possible to govern."

(Miller and Rose, 1990, p. 8).

This might be able to address wider and seemingly complex questions that emanated from the directive to write care plans in the first person. According to Foucault (1977a) power operates at a local level through a multiplicity of dispersed sites within society. Analysis is therefore directed at the variety of

everyday and mundane processes that shape subjects. This approach has been defined as focusing on: “the social practices that constitute everyday life in modern societies” Fraser (1989, p18). Therefore, analysis should have a bottom-up approach, starting from a micro-level to reveal the particular theories, or techniques of power. It might be that contemporary society can be better understood with a study such as this, at a site where power is physically administered or physically endured or resisted (Waltzer, 1986).

The next section will explore the assumption of a genealogical approach that knowledge (which might inform the CPA) is intimately connected with power. Knowledge is understood in an eclectic way, to include: discourses, practices, techniques, experiments, and institutions.

“We should admit rather that power produces knowledge; that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge.”

(Foucault, 1977a, p. 27).

In the case of the mental health system its knowledge might include techniques (from the care plan to administering rapid tranquilization), knowledgeable persons (from psychiatrists to social workers), theories (from the dopamine hypothesis for schizophrenia to cognitive-behaviourism) and schemes (from care in the community to the quasi-market in the NHS).

Knowledge is regarded as dependent upon the social, political, economic, cultural, and historical conditions of the time. Its connection to power has been described as a “fundamental instrument in the constitution of industrial capitalism and the type of society that is its accompaniment” (Smart, 1985 p.72). This study will position mental health services and the power they hold, in the context of the type of modern society that has evolved in the West. This is linked to the notion of disciplinary power described by Michael Foucault in *Discipline and Punish* (1977a). Disciplinary power refers to social processes of normalisation through which certain ideas become taken for granted. Foucault (1977a) describes the

concept of the Panopticon; a design of the prison by English philosopher Jeremy Bentham which allowed the guards to observe inmates without them knowing they were being watched. The prisoners who knew that they were being viewed regulated their behavior. This model has been applied to wider society as individuals assume that they are under surveillance, internalising a code of social order. A process of self-evaluation begins under the perceived scrutiny. This process of normalisation is not conceived in negative terms, but is arguably what is required for society to reach its potential.

“We must cease once and for all to describe the effects of power in negative terms: it ‘excludes’, it ‘represses’, it ‘censors’, it ‘abstracts’. It ‘masks’, it ‘conceals’. In fact power produces; it provides reality; it produces domains; objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production”.

(Foucault, 1977a: 194).

Genealogy is a unique type of history telling, described as a problem-based approach to history, in the sense that it becomes a critical analysis of power relations in the present (Kendall and Wickham, 1999). This distinctive approach to history makes tactical use of knowledge available to the researcher. It attempts in some way to disturb what is taken for granted and seeks to bring lesser known knowledges to life, such as the patients’ view of the mental health system.

Unlike other methodologies perhaps more familiar to the clinical psychologist, the genealogy does not have a set of procedures or protocols to follow. However, some common factors have been described (Kendall and Wickham, 1999 p, 34). The genealogy:

- Describes statements but with an emphasis on power;
- Introduces power through a ‘history of the present’;
- Describes statements as on ongoing process, rather than a snapshot of discourses;

- Concentrates on the strategic use of historical material to answer problems about the present.

The strategic use of historical material in this study might be to consider the differences and contingencies between different periods in history or to consider the conditions of possibility necessary for the emergence of the CPA. A condition of possibility is a philosophical concept used to establish the necessary framework for the possible appearance of given entities. In this way the thesis is a genealogy of “emergence” with the aim to identify particular historical developments. The study does not consider “descent” which is another aspect of a genealogical methodology used in consideration of a particular race or social group or race (Foucault, 1977b).

The literature review presented above has provided a cursory map of the problem of the CPA. Under different conditions an alternative to the CPA may have been devised such as a non-administrative solution to community care. The period 1948-2013 was considered as the CPA as a technology of power is linked to the post-war developments of the welfare state and the establishment of a Nationalised Health Service, which are considered to be conditions of possibility for the CPA.

This might seek to question supposed certainties which are taken for granted in the history of mental health. For example, commentators have suggested that there are different versions of the history of psychiatry (Shorter, 1997), and Ingleby (1983) criticises historians who tokenistically add patients to the history of professional and legal frameworks:

“Like historians of the colonial wars, these accounts tell us more about the relations between the imperial powers than about the ‘third world’ of the mentally ill themselves”

(Ingleby, 1983, p.142).

This section has described the understanding of genealogy for the purposes of this study. The next section will describe why a historical / genealogical approach was chosen to address the CPA.

1.3.1 The Rationale for a Genealogy

A genealogical approach allows the use of the CPA as a starting point for an exploration of wider themes affecting mental health services. In this way it might be able to combine an analysis of Government policy, management strategies, and the organisational cultures of NHS services and the “apparently humble and mundane” (Miller and Rose, 1990, p.3) techniques and interactions that occur between the professional and the patient (Hillman et al, 2013).

Of particular interest here might be the investigation of governmentality in mental health services. Governmentality is a theory developed by Michael Foucault and developed by theorists such as Michael Callon (1986) and Miller and Rose (1990) to describe the way in which governments produce citizens (both professionals and patients) best suited to fulfill their objectives, and how organised practices (such as the CPA) can influence the way subjects are governed:

“an ensemble formed by the institutions, procedures, analyses and reflections and calculations and tactics that allow the exercise of this very specific albeit complex form of power.”

(Foucault, 1979, p 20).

Bruno Latour (1987, p.219) developed a notion of “action at a distance”: “how is it possible to act on events, places and people that are unfamiliar and a long way away?” The CPA could be conceptualised as a means for this “action at a distance”, of particular note in this context might be the way in which the use of the CPA might shape the work of both professionals and patients, hence it could be conceptualised as a government technology are defined below:

“Technologies are practical forms of rationality for the government of self and others. There are two kinds of technologies appropriate for psychological inquiry: power and self. Technologies of power seek to govern human conduct at a distance while technologies of the self are techniques by which human beings seek to regulate and enhance their own conduct”.

(Arribas-Ayllon and Walkerdine, 2008, p.99).

The care plan could be conceptualised as a technology of power in the sense that it involves the shaping of subjectivity of both professionals and patients. It could also be conceptualised as a technology of the self in the sense of encouraging the patient to get better through a process of self reflection and self discipline. It is likely that human identity is constructed by a range of practices that act upon human conduct through the process of subjectification which is defined below:

“Subjectification refers to ... self-formation. How do subjects seek to fashion and transform themselves....Through which practices and by what authority do subjects seek to regulate themselves?”

(Arribas-Ayllon and Walkerdine, 2008, p.99).

Foucault (1982) describes technologies of the self by which humans come to understand who they are. Human identity is constructed by a range of practices that act upon human conduct. For example, the patient requests further treatment that may have initially been coercively applied. Rodgers and Pilgrim (2001) explain this as a shift from repressive power to disciplinary power of mental health services. This links to Foucault’s suggestion not to concentrate solely on the repressive effects, but to concentrate on the positive aspects too. Here, patients are not being repressed, instead authorities are concerned with how they can promote certain subjectivities (such as those aligned with recovery). In this way, individuals are both created by power, and also, a means through which

power is expressed, which creates the opportunity for positive as well as repressive power (Smart, 1985).

1.3.2 Reflexivity

From a Foucauldian perspective, all forms of knowledge are derived from discourse, especially knowledge from academia/science. This thesis therefore represents a discursive construction that exists within a discursive framework. As Rose and Miller (1992) suggest, this approach moves away from facts to be interpreted, as facts themselves are constructed out of the researcher's "will to truth". Burr (2003) explained that it is important for researchers adopting a position of reflexivity to make explicit their own perspective, which may have informed the research. It is important therefore to acknowledge the researcher's subjectivity in the role of trainee clinical psychologist; as defined (and constrained) within historical, cultural, and academic discourses (Harper, 2007).

1.3.3 The Structure of the Study

Indeed, for the purpose of a genealogy the aim is to attempt to step outside of these restrictions of subjectivity. This has implications for the structure; a conventional structure in the positivist tradition of "introduction, results, analysis, and discussion" has been abandoned in favour of an historical approach, with each Chapter representing a historical period (1945-1979, 1979-1990, 1990-2013) leading to a final chapter which will provide an overview of the study and provide an evaluation. In this way, there will be aspects of "introduction", "method" "analysis", and "discussion" throughout each Chapter. As mentioned earlier this has created certain dilemmas for the researcher in terms of how to structure the thesis, as there is not a prescribed structure to follow. It is acknowledged that this marks a departure with Foucault's principle of non-linearity in his genealogical works such as *Discipline and Punish* (Foucault, 1977a). However the linear structure presented here retains key genealogical principles such as its emphasis on power and its inter-relationship with

knowledge. It was decided that it made sense to have the research questions for the thesis at the end of this Chapter which are described below.

1.4 The Research Questions

When constructing the research questions it was important for them to be able to accommodate a genealogical methodology, which required them to be fairly broad in scope. The following study will problematise the Care Programme Approach asking the following questions:

1. Where does the CPA come from in recent history and what are its underlying assumptions?

2. What do these assumptions tell us about; (a) how mental health is constructed; (b) how the work of mental health services is constructed; and (c) how have those constructions have changed over time?

CHAPTER 2: 1945-1979

2.1 Introduction

Returning to the narrative of the study; wider aspects of the mental health system may be represented in the CPA. In the context of a genealogy the CPA will be conceptualised as a technology of power (Arribas-Ayllon and Walkerdine, 2007). This means that the CPA can be regarded as representing diverse elements of the mental health system such as policy priorities, the organisational culture of the National Health Service (NHS) and the every-day interactions of care provision (Hillman et al., 2013). The chapter will involve a discussion of the establishment of the welfare state, the modernisation of the NHS, and the beginnings of de-institutionalisation and community care as conditions of possibility for the CPA. It will end with a discussion of the taboo and perceived danger of mental illness in this period.

2.1.1 Governmentality

The period 1945-1979 as a starting point was chosen as it represents the foundations for a new mode of governance through the establishment of the welfare state. Liberalism and welfarism are considered to be cornerstones of the present day neoliberal form of rule, which will be examined in the next chapter. The aim of this chapter is to explore the conditions of possibility for “government at a distance” (Miller and Rose, 1990, p.8) through the establishment of the welfare state, which the CPA will become involved in.

Governmentality refers to the way authorities try to produce a citizen best suited to their objectives, using a range of organised practices (Foucault, 1991). The practices which began to emerge in this period include the application of statistics and management techniques from the 1960s in the NHS (Klien, 2001). As a technology of power the CPA shapes the way in which professionals think and go about their work with patients. This mode of control does not rely upon direct coercive strategies – instead it looks to indirect means of shaping practices which the citizen/professional engages in freely (Callon, 1986). The next section will discuss the origin of the welfare state (as derived in part from Keynesian

economics) and its development. This is important as the evolution of the welfare state with neoliberal ideas (discussed in the next chapter) is considered to be an important condition of possibility for the emergence of the CPA.

2.2 The Welfare State as a Condition of Possibility for the CPA

The timeframe begins with the establishment of the National Health Service in 1948, which took control of the large Victorian mental hospitals. The NHS was conceived from paradigmatic-changing economic theories developed by the liberal economist John Maynard Keynes (1883-1946) during the world recession of the 1930s. In “The General Theory of Employment, Interest and Money” (Keynes, 1936) Keynes advocated a reduction of interest rates and the increase in public expenditure on public services which he felt could promote full employment and have positive effects on the economy as a whole. During the Second World War such theories were promoted by the British Labour Party in opposition and gained popular appeal due to the wartime economic austerity, and from military personnel returning from war (Finlayson, 1994). Keynesian economic policy facilitated the growth in bureaucratic strategies (of which the CPA would later be one). The timeframe ends in 1979 which marks the end of welfarism and the start of neoliberalism (which would utilise and develop the established welfare network of bureaucratic strategies within which the CPA would later be conceived).

Considering the welfare state as a condition of possibility for “government at a distance” (Miller and Rose, 1990, p.8) and the CPA, this next section will consider some of the factors that may have given such prominence to the welfare state and Keynesian economics. The section will discuss first, liberalism as a declining political strategy in the context of industrialisation; second, the connection between liberalism as a strategy of control and the asylum; and third, the new strategies of control that came to the fore in the twentieth century. A consideration of the philosophy of liberalism and its derivative philosophies is important because in the next chapter the dominance of neoliberal modes of thinking will provide the conditions necessary for the CPA.

2.2.1 The Declining Relevance of Liberalism as a Strategy of Control

Liberalism is a political philosophy that emerged in the Enlightenment period in Western Europe. It came to prominence in England during the Industrial Revolution (roughly between 1780 and 1840). It is based on ideas such as liberty and equality in place of hereditary privilege, state religion, and absolute monarchy (Rose and Miller, 1992). The subjectivity (a process of self-formation) of that time was primarily moralistic and individualistic, as promoted by philanthropists (early moral and technical authorities). The features of this period of history can be interpreted by; the growth of liberal democracy; capitalism; industrialisation; and urbanisation (Lee and Newby, 1983). During this period the urban labouring classes grew exponentially, along with insecure employment and poor working conditions in the large factories. During this time government strategies, based on the philosophy of liberalism, were under considerable threat from this socio-economic change. Prominent threats included the growth of militant labour, trade unionism, and the establishment of the Labour Party in 1900. Moralistic forms of social control of the urban labouring classes, were becoming impotent in the face of social change, upheaval and increasing individualisation (Rose and Miller, 1992). This section has defined liberalism as a political philosophy and described how it was becoming increasingly outmoded in the context of industrialisation. The next section will discuss the relationship between liberalism and the asylum as a condition of possibility for community care and the CPA.

2.2.2 Liberalism and the Asylum

The liberal-moralistic authority prominent in the nineteenth century was applied to mental illness in the form of the large Victorian asylum. Porter (2002) describes the large-scale institutionalisation of mental illness during this period as a result of several factors: a market economy in asylums, the growth of a paternalistic conceptualisation of the State, and the move away from religion to scientific secularism. Those who could not meet their obligations to society were perceived as anti-social which gave legitimacy to the need for confinement of such groups unable to take their responsibilities as citizens. In England the number of patients in asylums rose from approximately 5,000 in 1800 (out of a total

population of 10 million) to 100,000 in 1900. London's Colney Hatch hospital (later renamed Friern Barnet) increased its residency from 1,200 in 1851 to 2,700 in 1937 (Porter, 2002). There was a growing concern of over-crowding and that the asylums were becoming sites to exclude undesirable citizens permanently from society. For example, at Ticehurst hospital, the median duration of admission ranged from 22 to 30 years (Scull, 1993). The treatment in the asylums primarily involved medication and restraint, and due to over-crowding the conditions were inhumane (Porter, 2002). This section has located the explosion of the asylum model within the liberal-moralistic mode of governance during industrialisation. The next section will discuss some of the new forms of knowledge that began to challenge the existing strategies of control.

2.2.3. New Forms of Knowledge and Power

In the second half of the nineteenth century new forms of knowledge were developing in the form of the positive sciences (e.g. economics, statistics, medicine, biology, psychiatry, psychology). Auguste Comte published "A general view of positivism" in 1848 which outlined the epistemological perspective of positivism. The role of the Church was increasingly being replaced by medicine, marking the transition from the religious to the medico-secular cure. For example, there was a change in the construction of mental illness from being sinful or lacking in belief to being marked out as irrational and mad. Behaviour previously conceived as sinful or bizarre was attributed to medical disorders that could be cured rather than be contained. Cartesian dualism had a strong bearing on the way in which medicine drew madness under its remit (Scull, 1991). The move from a religious to a secular-positivist control of mental illness reflected the wider changes strategies of social control. The next section will describe the welfare which is considered to be a condition of possibility for the CPA.

2.2.4 Welfarism and "Government at a Distance"

The moralistic subjectivity of the Victorian and Edwardian age was transformed by the post-Second World War welfare policies. Governments regarded citizens as individuals with needs to be governed through, a network of collective solidarities and dependencies (Rose and Miller, 1992). During the War, the liberal

economist William Beveridge (1879-1963) wrote the “Social Insurance and Allied Service Report”, proposing the expansion of National Insurance and the creation of the National Health Service (NHS). What became commonly known as the Beveridge Report (1942) formed the basis for the post-War “welfare state” established by the Labour government elected in 1945. It outlined the five “Giant Evils” of: squalor, ignorance, want, idleness, and disease. It proposed addressing these systematically. It would create a form of contract between the state and the people, in which needs and responsibilities would be clearly marked out and separated. The introduction of social insurance would attempt to establish collectivist mentality at large. The social insurance policy has been conceptualised as both inclusive and solidaristic (e.g. the collective social insurance model) and individualising and responsabilising (e.g. the social worker model ensuring citizens uphold their side of the bargain) (Rose and Miller, 1992). This section has outlined some of the features of the welfare state. The next section will discuss the emergence of alternative ideas during the period which will influence neoliberal thinking, which is a condition of possibility for the CPA.

2.2.5 Opposing Ideas to the Welfare State

This section will discuss alternative theories which emerged during this period (1945-1979) as a challenge to the “interventionist” models such as Beveridge’s welfare state. The network of welfare established a multiplicity of practices, techniques, practitioners, and procedures, which would endure, despite the strategic mutation of the welfare project in the 1980s away from collective dependencies and towards an ethos of individual responsibility. In his lectures at the College de France in 1979 entitled *The Birth of Biopolitics*, Michael Foucault described this as the development of “ordoliberalism” by a group of German intellectuals known as the Freiburg Group during the post-war period. They rejected the idea that the state should intervene to reduce social inequality caused by crises in the market economy (Foucault, 1979). They instead advocated government regulation of the economic markets. This challenged the view that the state should intervene to compensate for damaging effects of the market such as an economic crisis. Instead government intervention should support and enhance the economy throughout to establish fair competition.

Ordoliberalism could represent the cultural ascendance in the West of a rationalist individualism (Foucault, 1979). There was considerable debate in Britain, at the time, about the welfare state, with critics in the Conservative Party arguing that funding this expensive welfare system, when Britain's economy was still recovering from the War, would actually disadvantage the poorer sections of society as it hindered the UK economy (Barnett, 1995).

A more extreme version of this form of liberalism was articulated by Friedrich von Hayek (1944) in his seminal text, "The Road to Serfdom". In brief, he argues that state interventionism was comparable to the 'total state' regimes of Nazi Germany and Stalin's Soviet Union. The principle of individual freedom was considered to be the bedrock for modern civilisation. Hayek's ideas were considered to be an extreme version of the ideas of the Freiburg School developed in Germany. Hayek's ideas would characterise the economic and social reforms of the 1980s in the UK (which would influence mental health services).

This section has discussed how the welfare state in the context of the evolution of liberal philosophy as a condition of possibility for new strategies of government (which would later include the CPA). The next section will discuss in the context of the welfare state, how the NHS began to modernise, including the growth of bureaucratic strategies of which the CPA would later be one.

2.3 The Evolution of the National Health Service

This section will describe the politics involved in the inception of the NHS in 1948, and the influential role played by medical professionals in the 1940s and the 1950s, and the challenge to their authority by the rise to prominence of new administrative strategies in the 1960s. This transition in power is considered to be crucial to the study of the CPA as a representation of the regulatory strategies of Government.

Professional groups such as the British Medical Association (BMA) were highly critical of a nationalised health service, and were reluctant to show support (Klein, 2001). The BMA advocated a national service funded by National Insurance, not general taxation. Some doctors were so adamantly opposed that they threatened strike action. Bevan finally managed to win over the support of the vast majority of the medical profession by offering certain minor concessions, but without compromising on the fundamental principles of his NHS proposals. Bevan later gave the famous quote that, in order to broker the deal, he had "stuffed mouths with gold" (Klein, 2001). Also as a reward for their agreement, medical professionals were given a central role in the management of the NHS in this period. Mental health hospitals were brought under NHS control, although administration was separated between hospital authorities and local health authorities. Despite their initial reluctance to join the NHS, with its unwieldy bureaucracy, medics were to play an instrumental role in its early organisation and management.

2.3.1 The Role of Doctors in the Management of the NHS

The CPA is not allied to a particular professional group, in this sense it could be considered to be non-partisan, allied instead to the "regulatory state" (Klein, 2001) which began to emerge in this period. In the early stages of the NHS a complex bureaucratic infrastructure was created jointly between the Ministry of Health and the medical establishment. The Government was concerned that there was an absence of effective administration in the NHS. For example, the Ministry of Health did not have a record of the number of doctors and how they were distributed. Medics were able to control the early administrative infrastructure - establishing programmes to create information in the form of limitations, norms, and standards. Due to advances in medical science the medical professionals were highly regarded in society which may have contributed towards this early powerful position in shaping the NHS policy agenda, and keeping non-medical professionals outside.

During these early days of the NHS, the proportion of NHS workers belonging to trade unions rose from 40 per cent to 60 per cent suggesting that the power of corporate interest groups was on the increase (Klein, 2001).

2.3.2 New Technologies of Government

The medical-administrative dominance continued throughout the 1960s and it was not until the 1970s that it was finally breached by non-medical managers (Rose and Miller, 1992). During the 1960s the Ministry of Health began introducing some new administrative techniques that challenged the influence of the medical professional in this area. For example in 1961 the Plowden Report said that it would be desirable to expand the use of mathematical techniques, statistics, and accountancy (Rose and Miller, 1992). These new techniques would enable civil servants to calculate and control public expenditure. Also in 1959 the Ministry of Health set up its Advisory Committee for Management Efficiency (Klein, 2001). Health economists began to emerge establishing themselves in the civil services and promoting central planning using rationalised technologies of management and monetarisation.

This section has described the rise to prominence of administrative technologies which began to displace the control of the medical professionals in the administrative arena. The continuing rise of an administrative-disciplinary culture in the NHS will be developed further in the next chapter. However, next it is important to consider the early soundings for de-institutionalisation, which would be a condition of possibility for CPA.

2.4 De-institutionalisation

This section will describe the start of the process by which the Victorian mental hospitals were to be closed, the slow pace of implementation and the eventual inception of community care as conditions of possibility for the CPA. The political mandate for de-institutionalisation was influenced by a range of factors: the institutional model was perceived as economically unsustainable; humanitarian concerns regarding over crowding and hospital scandals; developments in psychopharmacology; and the Government's ambition to expand the power of

psychiatry and its affiliated professions. The political rhetoric in favour of de-institutionalisation was initiated by Enoch Powell (the then Minister for Health) and his famous Water Towers speech in 1961;

“There they stand...isolated, majestic, imperious, brooded over by gigantic water towers, rising unmistakable and daunting out of the countryside - the asylums our forefathers built”

(Roberts, 2013).

This reflects a break with the Victorian past and the development of the modern State, with distant visions of community mental health services, conceived by the welfare state, a post-asylum age. This break with the past, was a vital time for the conditions of possibility for the emergence of the CPA in 1991. However whilst some early community and district hospital services were set up in this period, both the process of hospital closure and the development of community psychiatry were slow to develop. The number of day hospitals increased from 2 in 1949 to 65 in 1966, by 1975 there were 6,000 day hospital places, and by 1981 there were 15,300 (Boardman, 2003). This will be considered in the next chapter (1979-1990). Scull (1977) has suggested that the government wanted to minimise public expenditure at this time, and saw the closure of the large Victorian institutions as a good way of saving costs. Rogers and Pilgrim (2001) suggest that the economic argument is more relevant in the 1970s than the 1950s and that it is important to consider some of the humanitarian advocates for social reform, exposing abusive treatment in the asylums (Davidge et al. 1993).

The relationship between deinstitutionalisation and establishment of the welfare state / NHS is important to bear in mind as a condition of possibility for the CPA. Mental health and its affiliated disciplines became a central component of the NHS welfare system. Occupancy of mental health beds reached its peak in 1955 at approximately 148,100, which accounted for nearly half the NHS' hospital beds including general medicine (Boardman, 2003). The development of rationalised costing technologies in the NHS (mentioned in the previous section) highlighted the vast expense of maintaining the mental health hospitals. In 1961 the Ministry

of Health began the long-term planning of hospital services and the Ministry of Health used statistical techniques to make projective forecasts on hospital closures. The use of these strategies can be demonstrated in The Hospital Plan in 1962. It envisaged cutting beds from 151,899 (in 1960) to 99,090 by 1975; closing of 13 of the existing 109 hospitals with 400 beds or more by 1975; the possible closure of another nine of the large hospitals after 1975, leaving 87 to continue indefinitely. Most of the long term care would be provided by the old hospitals, the size of most would be reduced, but 25 would still have 1,000 or more beds by 1975 (DH, 1962).

2.4.1 The Augmented Role of Psychiatry

The 1959 Mental Health Act placed psychiatry on an equal footing with other branches of medicine and psychiatry was therefore established at the top of the professional hierarchy of NHS mental health services. However it was not a deliberate intention of the psychiatric profession to gain this position of prominence (Rogers and Pilgrim, 2001). It may have been the government's intention to promote psychiatry and to increase the sites at which psychiatry could be administered (no longer limited to the Victorian hospital). The central role given to psychiatry is of particular interest, in its evolution from a static role within the asylum to a more mobile role associated with the community. The 1959 Mental Health Act pointed towards the pivotal role psychiatry would play in the future of mental health provision and a post-asylum future:

“the modern dispensation of psychiatry, far from being merely repressive or negative has constituted a new discipline of mental health”

(Rose, 1986, p 83).

This would lead to an evolved role in the network of welfare; such as working in primary care and community settings, managing a range of other professional groups. In 1953 the newly elected Conservative government announced the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency under Lord Percy which led to the publication of The Percy Report in 1957. The

Royal Commission recommended that mental disorder should be regarded in the same way as physical illness; and hospitals for mental illness should be run as nearly as possible like those for medical disorders.

“that the law should be altered so that whenever possible suitable care may be provided for mentally disordered patients with no more restriction of liberty or legal formality than is applied to people who need care because of other types of illness, disability or social difficulty”

(Percy Commission, 1957, paragraph 7).

The 1959 Mental Health Act followed these recommendations, essentially extending the authority of psychiatry. For example it made compulsory detention primarily a medical decision and removed the routine involvement of the courts. The medical profession requested to the Percy Commission that the courts should keep their power to detain patients in hospital, and allow the courts to hear appeals from any patient who has been forcibly detained.

The overall objective of the 1959 Act was to reduce the number of patients subject to compulsory treatment, with a greater emphasis on voluntary and short-term admissions. It wanted to encourage hospital admission to be as informal as those for physical reasons, and to make councils responsible for the social care of people who did not need in-patient medical treatment. It is in keeping with the welfare project which the country was engaged in, to increase opportunities for the expansion of professional experts and their knowledge to be disseminated.

2.4.2 Psychiatric Documentation

It is important to note that the CPA emerged in an era of community care and information technology, and computers. In this period (1945-1979) documentation was handwritten and primarily associated with the mental hospital. The hospitals were organised by a structured hierarchy based on a medical narrative. The medical super-intendant assumed overall control of the other medical and nursing staff and care staff, with the patients at the bottom of the hierarchy. Davies’

(2002) via the use of oral histories from ex-patients of the old mental hospitals, conveys the notion of a passive patient, as an object, being acted upon. This does not suggest that there were collaborative notions of care. Mental health hospitals kept medical records and case notes which were written by the medical professionals only, and only they would have access to them (Rogers and Pilgrim, 2001). The present situation is considerably different, where patients are given a copy of their CPA, and they can request copies of their notes. In the 1950s patients would not have access to their records, nor be able to influence how they were written. In keeping with the medical hierarchy nursing staff would keep separate notes and they were not allowed to have access to the notes of the psychiatrist (Porter, 2002). Also in contrast to the present day situation of community care, medical records during this period were primarily concerned with the patient's entrance into the mental health system, as opposed to their exit (Davies, 2002).

So far this section has discussed how this period was different from the present day however, contingencies with the present day might include the persisting need for psychiatric documentation as a permanent record, that follows patients throughout their contact with services, creating a "psychiatric identity" within a psychiatric discourse (Soyland, 1994). The act of creating psychiatric documentation converts rich descriptive patient stories into professional "case histories", with a structure and linearity that fits psychiatric theory (Hak and De Boer, 1995). The patient adapts to questions that the psychiatrist asks, and their descriptions of themselves (within the bounds of facts and their patient identity) are useful to the documentation process (Soyland, 1994). A similar process of subjectification is likely to exist in modern services, albeit with a different emphasis. This section has discussed some of the contingencies and differences associated with psychiatric documentation, the next section will discuss the role of medication as a condition of possibility for the CPA.

2.4.3 Psychiatric Interventions

One of the functions of the CPA is to document the patient's medication history and their current medication programme. The discoveries in psychiatric medication in the 1950s would resonate in the preceding decades leading up to the introduction of the CPA. Some commentators have suggested that discoveries in neuroleptic medication were a causal factor in hospital closure, enabling psychiatrists to discharge patients into the community. Others have countered this claim, suggesting that this does not account for why discharge policies also affected other groups such as older adults who did not yet have neuroleptic interventions; and in some European countries bed numbers actually increased after the widespread introduction of neuroleptics (Rogers and Pilgrim, 2001).

Historically there has been a long legacy of chemical experimentation with psychiatric patients. This had primarily been in the form of tranquilization. However the modern era of psychopharmacology can be demarcated by the discovery and rapid/wide distribution of chlorpromazine in the 1950s. Developed from antihistamines, Pierre Deniker and Jean Delaney first administered it clinically in a hospital outside of Paris in 1952 (Rose, 2003). It was patented by SmithKline and French and marketed in North America as Thorazine. In one year, 1955 it recorded profits of \$75 million. Unlike previous chemical interventions chlorpromazine was pitched as having a unique selling point; that it acted on specific symptoms of an underlying biological disorder rather than acting as a general sedative. These new drugs which would become known as "anti-psychotics" were administered by psychiatrists, as before. That is they considered them to act as effective tranquillisers. This section has discussed the influential role of the discovery of neuroleptics and their wide uptake by mental health services. The next section will discuss how the concept of "the community" and more specifically community mental health services began to be conceived of in this period.

2.5 The Birth of the Community

The process of deinstitutionalisation can be conceptualised as a dialectic form of change (Hamlin and Oakes, 2008). That is to say the discourse of the hospital had to be set against an alternative discourse: “the community”. While the closure of the large hospitals may have achieved the structural change desired, it is important to return to the relationship between patients and their experts, and their “communities”, to investigate contingencies. The exploration of discourses that have characterised the mental patient over the years might demonstrate which have survived or even flourished from the hospital to the community. First it is important to deconstruct what is commonly referred to in the professional vernacular as “community”. The term had been long present in popular and intellectual discourse. For example, the sociologist Tonnies’ (1957) portrayal of the rise of urban industrialism resulting in the loss of community.

2.5.1 Community and Political Activism

Political activists used the community discourse in the 1960s as a remedy for the ills of individualization, loneliness, and isolation engendered by mass society. This included ideas such as promoting lost authenticity and common belonging, and opposing the faceless, inhuman bureaucracy which they perceived to control society. Activists in the 1960s would identify with people at the margins of society such as those with mental illness, the homeless, or those living in ghettoised housing projects (Rose, 1996). At around the same time, these discourses of community with strong associations of resistance were co-opted by the emerging and rapidly expanding professional groups and their expanding expert knowledges (Ife, 1995).

2.5.2 The Community and Experts

“Community phenomenon” (such as mental illness) were to be taken into the remit of academics, and professionals: to be assessed and interpreted in such a detailed and thorough way that had not been known before. Although mental health patients had long been subjects of expert investigation in hospital; being discharged they would be investigated, and classified, and interpreted as community phenomenon not hospital phenomenon.

In his famous “Water Tower’s” speech in 1961 Enoch Powell alluded to the growth of new professionals to facilitate the expansion of community services:

“In this year, 1961 we intend to erect the scaffolding of a professional training for the social worker, and to link that with the training of other elements in the staff of community services”

(Roberts, 2013).

Following the Second World War there was an exponential growth in experts to set up and administer the new services, and a “professional society” was created (Perkin, 1989). In the field of mental health new professions included social workers, occupational therapists, clinical psychologists who would learn “a way of being” as an authority and learning the “conduct of conduct” (Rose, 1996).

Miller and Rose (1992) compare the contradictory nature of the welfare state: between the inclusive discourses attributed to policies such as social insurance, versus the responsabilising discourses attributed to the growth of social work. Social work functions to teach unwilling citizens and their families the correct way for responsible citizenship; offering rewards or possibly sanctions.

Patients are at the centre or on the periphery of a network of actors such as the family, the GP, the psychiatrist and the care co-ordinator. These actors are associated with a range of micro-locations where the behavior of a citizen can be problematised and acted upon by expert knowledges. As such, government does not wish to govern by coercive means but through education and persuasion, shaping the desires and behaviours of citizens to enable them to become “self-governing”.

2.5.3 The Hospital as a Community

Due to the hierarchical medical structure of the mental hospital it may be considered therefore that there was no resistance in hospital, power was one-sided, and the patient was constructed as passive. Goffman (1961) somewhat challenged this by reporting on his observations of inter-patient bartering systems which could be considered as challenging or subverting the established medical

hierarchies. Bartering existed in in material goods such as cigarettes, food, money, or favours. It also involved the sharing of expert knowledges about experiencing the new treatments, communicated through a patient-based shared language of the hospital with a shorthand language (e.g. “Meds”). Commentators such as Diana Gittens (1998) highlight the negative impact that the closure of hospitals had on people’s lives and the difficulties patients experienced having to adjust to the world outside.

2.5.3 Early Developments in Community Care

In the case of mental health services, “the community” would not be fully realised until the 1990s, where the “Community Mental Health Teams” and the “Community Psychiatric Nurse” were formally established. From its inception, the NHS was to include provision for people experiencing mental distress, taking control of the old municipal mental hospitals. These had originally been funded by philanthropists, a form of moral authority. The development of the welfare state included the introduction of public housing, an increased role for primary care services, and the introduction of psychiatric social workers employed by local authorities (Boardman, 2005). The introduction of these initiatives in the 1950s and 1960s began the process of the closure of the large mental health hospitals and the emergence of “community care” in the late 1980s. The Mental After Care Association (MACA) was established in the 1950s and provided residential homes for up to 50 people. Day hospitals, hostels, and therapeutic social clubs were set up to provide support for recently discharged patients (Rogers and Pilgrim, 2001).

There had been a fundamental change in where care was provided. The hospital was the centre of mental health provision, but its role became reduced with the rise of the community-based services. Some research has suggested that this changing “site” of care created a sense of confusion and displacement amongst patients who had made their lives in the institutions (Gittens, 1998). Barham and Hayward (1991) suggest, patients carried with them the “cultural freight” of mental illness which made it difficult for them to integrate into mainstream society. Labeling theories suggested that mental illness was effected by a combination of social practices that subtly reinforced their difference with is considered to be

normal (Scheff, 1966). Rosenhan (1973) demonstrated this empirically whereby normal behaviours performed by a person not in distress, were interpreted as symptoms of mental illness solely on the basis that the person was a patient in a mental health hospital. Although the site of treatment has changed, as mentioned in the previous section on documentation, the process of creating a psychiatric identity still remains (Soyland, 1994). This section has discussed the emergence of “the community” and its difference to the hospital. The next section will discuss how mental illness was perceived by wider society during this time.

2.5 The Taboo and Danger of Mental Illness

During this period the networks of welfare were being assembled and expanded, the Victorian mental health hospitals were still segregated from society at large and mental illness remained as a taboo subject. Commentators have suggested that during this period mental patients were conceived as being dangerous; however they were not yet represented by the pervasive risk discourse that prevails in the present day (Castel, 1991). It is this transformation from “dangerousness” to “risk” that creates a condition of possibility for the CPA. A 1969 study of community attitudes to mental illness in Edinburgh showed that there were stereotypes of mental illness, such as people being potentially unpredictable and violent, and “a fear of contagion from the still dreaded affliction” (Maclean, 1969 p.50) Some academic studies in the 1950s explored the effect of the entertainment media’s presentations of mental illness, and demonstrated that people with mental illness are perceived to be recognisably different in appearance, in their behaviours, standing out as deviant or bizarre (Nunally, 1961). This contributed to the view that the mass media images of mental illness perpetuates the perception of difference and potential dangerousness associated with mental illness. During this period there began to be some more moderate representations of mental health issues in the mainstream British media, for example the Archers radio programme featured a character being admitted to a mental hospital in 1954 and The Hurt Mind was the first television documentary in 1957 to film inside a mental hospital (Roberts, 2013). These portrayed less of a shocking, or dangerous stereotype of mental illness. A large nationwide study eliciting public opinion on mental illness in the USA however reported considerable public fear:

“Mental illness is a very threatening, and not an idea to be entertained lightly about anyone...as both our data and other studies make clear, mental illness is something that people want to keep as far from themselves as possible”

(Star, 1950, p.46).

It seems that mental illness was a taboo subject in this period of history, and people with mental illness were portrayed in the media as recognisably different. To some extent this is contingent with the situation in the present day. However the study will go on to examine in the next chapter the emergence of the strong association between mental illness and the risk discourse associated with the failure of community services.

CHAPTER 3: 1979-1990

3.1 Introduction

This chapter will continue (as the CPA had not yet emerged) with an analysis of its conditions of possibility. This will involve the following: a discussion of the continued evolution of the welfare state towards neoliberalism; an analysis of the establishment of a new public management culture in the NHS; the emergence of a consumerist discourse, the transition from de-institutionalisation to community care; and the emergence of the risk discourse.

Returning to the narrative of the study; wider aspects of the mental health system may be represented by the CPA. The study has conceptualised the CPA as a technology of power (to govern human conduct at a distance) (Arribas-Ayllon and Walkerdine, 2008, p.99). The CPA represents elements of government policy priorities, and managerial strategies of control. This chapter will build on the narrative of governmentality, meaning professionals are shaped to conform to the priorities of Government so that they self-regulate. The CPA has been conceptualised as a technology of power, governing the conduct of professionals to conform to new assumptions of mental health. These assumptions might include: care in the community as opposed to the hospital; planning care on an individual rather than collective basis; and the need to identify, monitor, and reduce the perceived risk posed by patients.

In considering the conditions of possibility for the CPA the emphasis is less upon explaining the cause of the CPA but to explore the questions authorities may have asked themselves during this period such as: "what is our power; to what ends should it be exercised; and how can we know what we need to do what we need to do in order to govern?" (Miller and Rose, 2008 p. 57). Therefore the chapter will begin with the new ideas of Government, and accompanying bureaucratic strategies that were implemented during this period.

3.2 From the Welfare State to the Regulatory State

This section will analyse the conditions of possibility for the CPA in the context of

the transition from the welfare state to the “regulatory state” (Klein, 2001). The organisational function of the CPA can be considered as a microcosm of this new regulatory state, reflecting how power is exercised in late modern society.

Returning to the ideas presented in the previous chapter; during the 1960s there was some criticism of the welfare state; however the economic theories of Friedrich Von Hayek were considered to be extreme and slightly eccentric within the mainstream political discourse. However during the 1980s these ideas began to dominate the discourses of mainstream political agendas.

Following economic prosperity throughout the 1950s and 1960s, with high employment rates and economic growth, there was a period of economic crisis during the 1970s associated with inflation and industrial unrest (Moncrieff, 2008). This marked a departure from Keynesian economics and the interventionist state that had greatly influenced the post-war period. The introduction of “monetarist” economic policies involved increasing interest rates, and reducing government spending in order to reduce interest rates (Moncrieff, 2008).

The theories of Hayek reactivated liberal principles of the nineteenth century, gained popular appeal and were adopted by the incoming Government of 1979. These principles are now well versed, for example:

“markets replace government planning as regulators of the economy; elements of welfare government become commodified and regulated according to market principles; economic entrepreneurship replaces regulation; and active individual entrepreneurship replaces the dependency of responsible solidarity”

(Rose and Miller, 1992, p.32).

The ideas from this political philosophy influenced reforms within the public sector, such as introducing internal markets and targets, in the belief that they would promote efficiency and value for money (Klein, 2001). The next section will discuss how these reforms also created a culture of compliance and control, which has been termed the “regulatory state” (Klein, 2001).

To analyse the origins of the CPA as a technology of power it is important to consider the broad remit of social-political-cultural factors that led to the increase of managerial technologies that emerged in this period. Since its inception the CPA has been used as one of many performance indicators in the NHS. A performance indicator is a measurement tool to assess how well health services are completing objectives set by the executive. The performance indicators, which are based on Government specifications, are disseminated through the many levels of managerial authority in the NHS. They might include the proportion of CPAs completed or, as in the directive that inspired this study, the proportion of CPAs that are written in the first person singular. The next section will discuss the purpose and origins of a regulatory culture in the NHS.

This section will involve the discussion of organisational changes which occurred during this period and which were informed by neoliberal ideas. There are regarded as conditions of possibility for the emergence of the CPA in 1991. The section will include an analysis of the following: the use and evolution of existing bureaucratic infrastructure of the welfare state and the emergence of the “New Public Management” (Hood, 1991).

Klein (2001) has pointed to the seeming paradox of the Thatcher era of government. One of its priorities was to reduce the role of government, rolling back that state interventionism of the previous two decades. The simultaneous but contradictory objective of the Government was to increase the power of the State and reduce the power of professional interest groups and the trade unions. As discussed in the previous chapter medical professionals had initially gained significant authority in the management of the NHS. However, from the 1960s this was beginning to be undermined by new management strategies. The strong influence of the medical professionals which had been evident during the 1950s and 1960s, and the ongoing threat of strike action was perceived to be holding back economic efficiency in public services and economic growth in a time of recession (Klein, 2001). It was through the use of technologies of power (such as the CPA) that the executive began to transform the dynamics of the NHS, away from professional bodies and towards government endorsed management strategies and independent regulators such as the audit commission (Power,

1997). Having provided some background context to the priorities of government during this period and a changing atmosphere in the NHS the next section will discuss how the reforms were implemented.

The general approach towards the welfare state including the NHS was to keep the institutions and technologies that had been established; but to reform their dynamics (Rose and Miller, 1992). This was in keeping with the public sector technologies of government already existing. To increase its power the Government would utilise the bureaucratic network already in place. However, this network would be reoriented towards objective targets and numbers, thereby establishing a regulatory culture with associated technologies such as performance indicators to ensure that the objectives were measured and accountable (Power, 1997). It is a common misconception that the Thatcher administration dismantled the welfare state; actually public spending on welfare was considerably higher at the end of the Thatcher administration, and this was not only due to the additional spending from high unemployment (Hills, 1990). It seems therefore, that the welfare state is a necessary component of this mode of governance. It is also important to note that it was changing into a welfare state run on the basis individualist rather than collective assumptions.

As a technology of power the CPA would reflect this as it is designed to assess for individual needs of the patient rather than assessing the collective needs of patients. It would therefore fit into this new regulatory administrative network that was being established in the 1980s. For example, in 1984 the Financial Management Initiative (FMI) was established and seemed to encapsulate the new administrative style that would cause ripples throughout the NHS. The FMI initiated a mass production of performance indicators throughout the NHS (Klein, 2001). The FMI's strategy (i.e. setting objectives and measuring progress) shared the assumption with the previous era of NHS management - in the importance of central Government planning (Klein, 2001). However, new techniques were now being used by a different managerial approach, which aimed for power to be dispersed at a multitude of levels throughout the welfare network, not reaching to interfere with every aspect of the NHS; its aim was instead for "government at a distance" (Miller and Rose, 1990, p. 8). That is, to implant administrative

regulatory mechanisms throughout the NHS. The political strategies of the new regime worked towards establishing a kind of “automisation” of the state from direct controls over the actions and calculation of the welfare organisations. As a technology of power the CPA would ensure that professionals were operating in a standardised way, approved and monitored by the Government.

3.2.1 New Public Management (NPM)

The next section will further analyse this new regime of Government from which the CPA will emerge. Hood (1996) has referred to the reforms during the 1980s as “New Public Management” (NPM). This view of bureaucracy is hierarchical, with a top-down perspective, for example; measurement (related to standards); targets (related to budget); the role of management to manage people and budgets; and an ethos of control (Seddon, 2009). The first Griffiths report (1983) encapsulates the reform regime that would establish the organisational paradigm of the NHS to this day. In the words of Leo Tolstoy; “there are no conditions of life to which a man cannot get accustomed, especially if they are accepted by everyone around him” (Tolstoy, 1878, p. 696). NPM has now become so deeply embedded into the culture of the NHS it is difficult for thinking to happen outside of this paradigm.

NPM represents a set of ideas transferred from private sector administrative practice, placing greater emphasis on rationalised bureaucracy as a means of social/organisational control. These ideas included: cost control, financial transparency, decentralisation of management authority and the creation of quasi market mechanisms separating purchasing and providing functions (Power, 1997). The NPM approach presumes that traditional forms of hierarchical bureaucracy are inefficient and outmoded for the complexity of the modern world, and should be replaced by the efficiency of the markets. Ideas of decentralisation of management authority are especially relevant to the CPA as a technology of power in mental health services, as the previous paternalistic/centralised mode of authority linked to the asylum was displaced. This section has discussed NPM

and its impact on mental health services. The next section will discuss how it influenced Government policy.

In a direct challenge to Keynesian models, hierarchical and centralised bureaucracies of the 1940s were considered to be out of date, and unable to accommodate the “data heavy” economy of the modern world (Power, 1997). The role of data, information, and planning in the 1980s are conditions of possibility for the emergence of the CPA in the 1990s. Two quotations from the Griffiths report bring this new approach to management to the fore: “to instill a more thrusting and committed style of management” and “if Florence Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge” (Griffiths, 1983, p.16). The recommendations of the first Griffiths report (1983) involved the following:

- The appointment of general managers at all levels of the NHS (regional, district, and unit);
- A Department of Health Services Supervisory Board to oversee policy and strategy;
- A NHS Management Board, to implement the above;
- Management budgets involving clinicians.
- The views of users, patients and communities being more actively sought and acted upon.

The 1983 Griffiths report demonstrated the Government’s ambition to increase its power, and to reduce the power of corporate groups such as the BMA and the trade unions. This ran contrary to the 1979 Royal Commission’s suggestion to create an independent health commission to provide greater leadership to the NHS (Klein, 2001). This adds to why it is important to consider the analysis of the emergence of the CPA in relation to power as the NHS is inherently involves power and politics, although this is often not made transparent. As a result of the Griffiths report general managers were introduced at every level of the NHS. This marked the start of assertive management which would curtail the power and influence of the professionals. This established a managerial culture in the NHS

that was seemingly neutral and depoliticised, and therefore it was difficult to identify and/or oppose. It was based on the assumption that professionals need to be monitored and regulated to increase performance and value for money. Therefore the CPA, as a technology of power, would be part of a network of strategies that foster a kind of “automisation” in services, staff begin to adopt such administrative practices into their work routine so that they become part of their professional identity. This could be an example of what Miller and Rose (1990, p.8) have termed “government at a distance”.

The Government in the 1980s proposed that public services had become too focused on provider interest, an internal market would simulate the free market which was intended to motivate professionals to achieve the targets that have been set for them. This implies that the public sector worker was not working for public interest but ultimately acting in their own interest (Hood, 1991). This has been challenged by other management approaches such as Deming’s “Total Quality Approach” (TQA) in the systems thinking tradition (Deming and Edwards, 1986). Systems thinking emphasises that people are shaped by the rules of the workplace (i.e. a target driven culture might elicit certain types behaviours such as competitiveness, rivalry and professional defensiveness). The CPA will emerge as an administrative solution for such complex issues as inter-agency working. The rhetoric of “performance management” (the CPA will come to be a “performance indicator”), suggests that there has been a shift from a “rules-based” tradition to a “results based” approach in recent decades (Hood and Scott, 2000). However it may actually be the case that it is even more rules-based than before, with a results-based veneer. For example the NPM is based upon the assumption that tighter compliance monitoring produces more effective public services. Commentators have suggested that it might in fact do the opposite, by eroding management philosophies which seek to promote collective over individual responsibility, such as the systems thinking approach. It might also underplay the potential for capacity building and performance accountability (Hood & Scott, 1999). The NPM is an important condition of possibility for the CPA, perhaps if there had been an alternative managerial philosophy an alternative non-administrative solution would have been applied to the problem of community care?

3.2.2 *The Audit Commission Community Care*

The next section will use the case of the Audit Commission, and its role in deinstitutionalisation, to illuminate the rise to prominence of what Michael Power (1997) has referred to as “the audit society”. The Audit Commission was established in 1982 and was responsible for Local Authorities, its remit was to conduct in-depth special studies and to identify weaknesses and points for reform (Kimmance, 1986). It was somewhat uncertain as to its partiality; as it was set up by, but independent of the executive and accountable to the secretary of state (Power, 1997). However, this is not to say that the Audit Commission has not been critical of central Government. Indeed, “Making Community Care a Reality” (1986) criticised the government for not pursuing the community care programme fully enough. It called for radical changes to the structure and management of mental health services. This report may be a stern reminder to Local Authority managers that they were tasked with an operation and that their performance in carrying it out now was being monitored (Power, 1997). In this way the Audit Commission was more than just a monitoring organisation, but also performed a consultancy role - shaping the future direction of Local Authorities. Its role in relation to community care is clear as it outlines its “grounds for concern”, “fundamental underlying problems”, and “radical changes needed” (Audit Commission, 1986).

Power (1997) describes the influential role that bodies such as the Audit Commission have assumed in the political sphere:

“as supreme audit bodies have grown in significance, political accountability to the electorate has been more explicitly supplemented, if not displaced by managerial conceptions of accountability embracing the need to deliver value for money”.

(Power, 1997, p.37).

The Audit Commission had a strong influence not only on promoting Care in the Community but also on the shaping of community provision, it therefore assumed

a kind of consultancy role. For example, the 1986 report clearly outlined how community services should be carried out. and advocated the presence of strong local “champions” of change. Further, it suggested that central co-ordination was necessary to integrate planning work with providers; thus augmented power of central Government. And finally, it advocated for a strong relationship between statutory and voluntary organisations (The Audit Commission, 1986).

The powerful role of the Audit Commission was indicated by Sir Roy Griffiths’ report “Community Care: Agenda for Action” which followed shortly after the Audit Commission’s report (DH,1988). Seemingly contrary to the Government’s distrust of devolved power, it placed renewed emphasis on Local Authorities, suggesting that local social service departments should design, organise and purchase all non-health related services. Perhaps this was an indication that the Executive was becoming increasingly confident in its regulatory network to achieve results? The local authority would act as a purchaser of voluntary and private sector services. To this extent the report proposes an internal market in community care opening it up for:

“maximum use of voluntary and private sector bodies to widen consumer choice, stimulate innovation and encourage efficacy”.

(Griffiths, 1988, p.6).

In reality there was not a multiplicity of purchasers, but one purchaser being the Local Authority social services departments (Klein, 2001). However, it appears that the agenda of neoliberalism was being implemented in community services. This is a condition of possibility for the CPA as it would provide the infrastructure by which services could be purchased. The second Griffiths Report (1988) has been criticised for over-estimating the ability of an internal market to increase efficiency. Initial concerns were raised that the new system would not effectively integrate different and often disparate services (with their own objectives, and practices). The key assumption behind the internal market was that the purchaser/ provider split would address significant problem of inter-agency working in community care. This problem has been identified in the previous decade. The 1975 White Paper, Better Services for the Mentally Ill (DH, 1975)

identified tensions for community provision of services and that local co-ordination and joint planning between health and local authority services would be essential. The CPA was introduced in part, as an administrative strategy that could address issues of inter-agency working which would become increasingly important in the next decade with discourses of “joined-up working”.

In 1989 the Government published its response to the Griffiths report (1988). The 1989 White Paper “Caring for People” supported the Griffiths report with the exception that it did not advocate protected funding for services. It conveyed similar assumptions such as the purchaser / provider split to improve the efficiency of the unwieldy State bureaucracy. By the late 1980s therefore the tone for community services was established along neoliberal principles of government. .

Table 2 The Gestation of the Care Programme Approach in the Context of Government Policy

1983	The first Griffiths Report on NHS management reorganisation.
1984	The Financial Management Initiative establishes performance indicators.
1985	Social Services Select Committee: first mention of need for care plan for discharge.
1986	Audit Commission: Making Making Community Care a Reality.
1988	The “Spokes Report” recommends care plans, register, and keyworkers.
1988	The second Griffiths report on community care.
1989	Response to the Griffiths Report. White Paper. Caring for People: Community Care in the next Decade and Beyond.

3.3 From De-Institutionalisation to Community Care

It was in the context of this new “regulatory state” in the late 1980s (Klein, 2001) that the plan for de-institutionalisation was finally given some momentum. In 1960 the total number of psychiatric beds in England and Wales was 151,899 (DH, 1962) in 1987 it was 67,122, by 2009 it was 25,503 (DH, 2010). As discussed in the previous chapter the foundations for the closure of the “Water Tower” hospitals was laid in the 1950s and the 1960s, however there was a general sense of malaise during the 1970s with seeming resistance to the bold plans of Enoch Powell and the cross-party consensus for the eventual closure of all 130 of Britain’s mental asylums. The 1975 White Paper report acknowledged that deinstitutionalisation was a long-term project of up to 25 years and it adopted a more tentative and somewhat pessimistic tone, stating that community care might be worse than the care received in hospitals. It highlighted some of the negative consequences of de-institutionalisation such as homelessness, and the burden placed on families (DH, 1975). This highlights the tentative notion of community care, its long-term development and its potential for failure. Such ambivalence is present in the Royal Commission on the NHS Report in 1979 advocated keeping the majority of the hospitals open, and that they would be required for as long as possible. Further, it stated that hospitals should only be closed if they were in very bad repair or were no longer needed due to population movement (Rogers and Pilgrim, 2001).

During the late 1970s when the new Government came to power the management of the NHS was still largely influenced by medical professionals and the state was ensconced within the welfare model which had allowed a powerful role for professional bodies and the trade unions at the heart of the NHS. Trade union groups had gained a position of influence in mental health services representing lower paid hospital workers such as psychiatric nurses, for example the Confederation of Health Service Employees (COHSE). At Brookwood Hospital (a 900-bed hospital in Surrey) the nursing staff announced they were to form a workers’ council to take charge of the hospital (Klein, 2001). This reflected the period of welfare state government that had allowed professional groups and

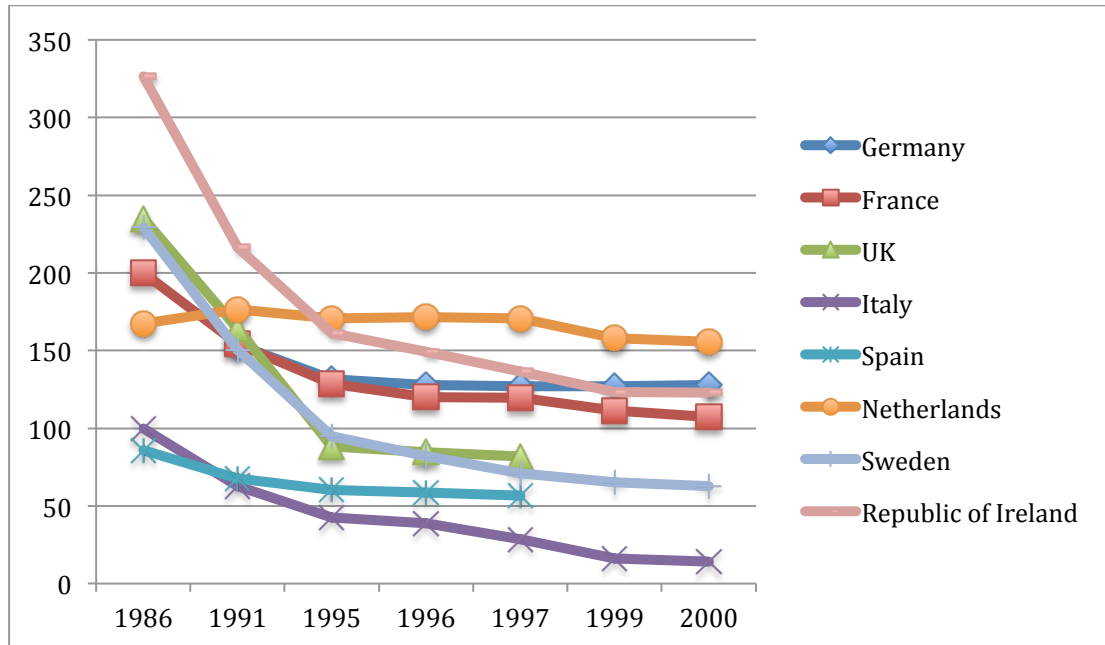
trade unions to hold some influence. However, this was now being curtailed. The conditions of possibility for community care and the CPA required that power be shifted away from hospital and traditional notions of the welfare state.

In order to implement change the Government needed to strengthen its position. It was not until the third Thatcher administration that attention was turned fully to the medical profession. The new mode of “government at a distance” (Miller and Rose, 1990, p.8) which sought to increase the power of the State through regulatory means, may have helped move the reforms along, i.e. the development of audit procedures establishing a mentality in the staff that was compliant with the directives from the Executive.

The Conservative Government held the closure of the mental hospitals high on their agenda. Whilst in opposition they commissioned a report which strongly endorsed the closure of the mental hospitals, highlighting the resistance of hospital staff and requiring local councils to implement the closures as a statutory duty, as well as offering financial incentives (Pilgrim and Rogers, 2001). Once elected in 1979 the Government did not publish the report straight away but waited until 1981 under the name “The Right Approach to Mental Health”, in the same year as a Green Paper was circulated entitled “Care in the Community” (Pilgrim and Rogers, 2001). It seems that the new Government was determined to galvanise the momentum for deinstitutionalisation.

It is important to note that most of the movement away from the hospitals happened from the late 1980s onwards, with over half of those closures happening from 1989-1993. By 1990, 35 of the mental hospitals had closed. The number of patients halved from an average of 468 patients per hospital in 1986 to 223 per hospital in 1993 (Davidge et al., 1993). The slow pace of closure during the 1970s and early 1980s meant that there was a gradual uptake of community service provision. Rogers and Pilgrim (2001) suggest that during the 1970s patients being discharged from hospital experienced a kind of re-institutionalisation in a poor standard of community provision.

Figure 1: The Reduction in Beds in Psychiatric Hospitals in Europe (Knapp et al., 2007).



NB figures are the number of beds per 100,000 of each country's population.

By the 1980s community services were beginning to take shape. The number of patients attending day centres increased from 3,403 in 1975 to 5,025 in 1982 and most of these were on hospital sites. The number of patients in homes and hostels increased from 3,911 in 1975 to 6,044 in 1981 (Boardman, 2003). In the late 1980s, 85 per cent of Government expenditure on mental health provision was still spent on hospital services and there were 79 Community Mental Health Centres (CMHC), with 49 more planned (Rogers and Pilgrim, 2001). By 1995 there were 500 CMHCs, and by 1997 there were 900 (Onyett et al., 1997).

Beardshaw and Morgan (1990) discuss several factors, which may have affected the rate at which the hospitals were closed, such as a fear of change; difficulties integrating an increasing plethora of services; and bureaucratic structures not being developed enough, to manage the financial transition from hospital to the community.

3.4 The Consumerist Discourse in Mental Health Services

The chapter will now turn to the emergence of the discourse of consumerism in mental health services, as connected to the expanding influence of the neoliberal philosophy in Government and wider society. As a technology of power the CPA is product of the the rise to prominence of neoliberalism and the decline of welfarism. Responsibilities for the management of mental health are being devolved to charities and private companies and regulated at a distance by mechanisms of audits, and standards. Perhaps this marked the transition from the paternalist and passive hospital approach to treatment to one of individual autonomy in the community. In this way the CPA could be considered as a technology of the self by which patients are encouraged to regulate and enhance their own conduct.

During the 1980s the new types of services encouraged the service user to choose the services they wanted and the second Griffiths report meant that local authorities were obliged to consult the user and their carers as to how services would be run. A consumer discourse emerged around this time which created the possibility of positive outcomes for the patient/consumer, such as increasing the emphasis on the individual rights of patients, for example the Mental Health Act, 1983 highlighted expectations of good standards of care. This may have contributed to a building discourse which was more questioning and doubtful in relation to the experts, reducing paternalism, and moving towards a consumerist position. The consumer discourse may have offered new benefits to psychiatric patients and opened doors that were previously were firmly closed. It is questionable however whether the individualistic, rights-based nature of the 1983 Mental Health Act was effective in responding to the wider structural changes in the health services, such as budgetary cuts. Instead it, worked on a case-by-case basis.

Speed (2007) suggests that the consumer discourse tends to favour the healthcare professional and the Government, and implicitly re-enforces the biomedical model. The consumerist discourse therefore becomes coterminous with the professional discourse. The rhetoric of “choice” and “empowerment” becomes quite restrictive and could be a way of dissipating resistance from

patients so that they become the right kind of patients (transformed into consumers), thereby adhering to the social norms such as individual responsibility and self-fulfilment. It is within the consumerist arena that the CPA would emerge in the next decade. The CPA would encourage patients to become self-regulators or self-entrepreneurs rather than being involved in collective resistance or political activism.

In line with the consumerist discourse, from the late 1970s there was an abundance of academic and professional literature and related practices related to aspects of “lifestyle” that contributed towards ill health (Peterson and Lupton, 1996). This could mark the emergence of a new discourse of “new public health” as something that could be acted upon and changed, the passive patient subject to paternalistic institutions is provided with the opportunity to become an agent of change, with professional guidance. This plethora of emerging knowledge and information provided individuals with advice on how to change their previously “risky” lifestyles. These health “pioneers” consider that the individual can be moulded into a rational and “profit-maximising” individual (Peterson and Lupton, 1996). These new public health discourses (and their representatives) would influence mental health services to some extent. However for those patients on the margins of society it would be questionable to what extent they would be amenable to such professional guidance.

3.5 Risk Discourses and Mental Health

The inertia for hospital closure during the 1970s and 1980s marks the transition into this new period of government where, in-keeping with its neoliberal agenda, the “risk” discourse relating to care in the community begins to emerge. In the mid-1980s the risk discourse is attached to people with mental illness, which will be further exacerbated in the 1990s. The difference in the 1990s is that the risk narrative is drawn to the failures in mental health policy and care in the community, which is one of the conditions of possibility for the CPA.

This study will adopt a constructionist analysis of risk as made up of social, cultural and political processes (Douglas, 1992). It is through such processes that

the dangers posed by the psychiatric population in the community become conceptualised within a broader risk discourse. This is not to argue that there are no 'real' dangers (sometimes fatal) but that there is added analytical value in exploring how depictions of mental illness associated with violence comes to influence social policy such as the implementation of the CPA.

High profile homicides in the 1990s may have greatly influenced the inception of the CPA, and these will be considered further in the next chapter. However, it was violence in hospitals, not in the community, that may have ignited the risk discourse related to mental health services and the mandate for more coercive means of control such as risk assessment (Rogers and Pilgrim, 2001). In 1984 a social worker (Isabel Shwartz) was killed by a patient (Sharon Campbell) in Bexley Hospital. The development of community care had been reported on by the national press. Some of these reports were sympathetic to the plight of patients receiving insufficient care. The Schwartz killing received wide press coverage, for example the Guardian on the 17th April 1985 reported that:

“if a series of telephoned threats had been believed at Bexley Mental Hospital’s social service department Isabel might not have been stabbed to death. Or if the security officer had not gone on leave that afternoon, leaving only the porter to stand in for him”.

And,

“there was inadequate liaison between social workers”.

(Paterson, 2006, p.297).

This established a pattern which would develop in the next decade, where following high-profile media cases a policy would be introduced in attempt to demonstrate Government control of the risk. Following the Schwartz killing the Government subsequently commissioned the Spokes Inquiry (DH, 1988) to investigate. It reported poor care provision for Campbell and concluded that there was no strategy to identify vulnerable patients who may pose a risk, or to form a rationalised approach to organising their care:

“...before discharge from in-patient treatment, a plan should be prepared for a psychiatric patient. The plan should set out the proposals for community care and the time when the plan will come up for review...”

(Department of Health and Social Security, 1988, p.16).

This would lead to the development of the CPA in 1991 as a technology of power with its allocation of experts to assess and control risk in society.

The 1985 Social Service Committee Report continued the recommendations of the Spokes inquiry:

“Nobody should be discharged from hospital without a practical individual care plan jointly devised by all concerned, communicated to all responsible for its implementation, and with a mechanism for monitoring its implementation or its modification in the light of changing conditions; and that the resources for this to be made available”

(Social Services Committee, 1985, at paragraph 45).

This indicates the increasing concern of authorities regarding the care of patients after they have been discharged and is, in part why they looked to the bureaucratic solution of an individual care plan. This was first applied to patients subject to aftercare under the Mental Health Act, 1983 by the Mental Health Act Commission in 1987:

“After-care plans for patients to whom Section 117 applies should be drawn up on a multidisciplinary basis as soon as possible after the patient is admitted, and liaison should take place prior to discharge between workers from the community and the hospital team...”

(The Mental Health Act Commission, 1987, p. 66).

This section has attempted to demonstrate the association between a homicide perpetrated by a psychiatric patient and media reports that implicate and blame public services. Government inquiries and legislation in response to homicides

involving psychiatric patients is suggestive of the emerging influence of the risk discourse. This will be developed further in the next chapter.

This chapter has explored the questions authorities may have asked themselves during this period such as “what is our power?” and “to what ends should it be exercised?” This has considered the introduction of the New Public Management philosophy into the NHS with accompanying strategies such as new managers at every level. The discussion implicated this new regulatory state in giving some momentum to the closure of the Victorian mental hospitals first mooted in 1961. It discussed in the rise of the consumer discourse in mental health services in relation to the neoliberal philosophy of individual responsibility. And finally it outlined the emergence of the risk discourse related to mental health services. The next chapter marks the arrival of the CPA, it will continue to develop the narrative of neoliberalism, the regulatory state, and the risk discourse as the CPA evolves.

CHAPTER 4: 1990-2013

4.1 Introduction

This period marks the emergence of the CPA (assessments, care planning, keyworkers and regular reviews) – the focus of this study. This chapter will analyse the CPAs emergence in 1991, and its evolution, which was documented in Chapter 1 and Table 1 (p.6). It will return to the relevant Government policies and Acts affecting the CPA and will draw upon the conditions of possibility that have been described in the previous two chapters. This will help to consider how mental health discourses and mental health services have been constructed, taking into account any contingencies or differences over time.

The chapter has been structured in three parts; first, it will pick up the narrative of the evolution from the welfare state into the “regulatory state” (Klein, 2001); second, it will involve an analysis of the CPA’s relationship to the risk discourse in community care, which gained in momentum from 1990 onwards (following high profile homicide inquiries); third, it will consider how the patient is constructed by the CPA (and how this might be different from the past).

4.2 The Arrival of the Care Programme Approach in the Context of the Regulatory State

The CPA was introduced by the Department of Health circular in 1990, and formally launched in April 1991. As discussed in chapter one, the CPA provides a method of structuring and organising the management of mental health patients both in hospital and the community. It was introduced at a time when the closure of all the large asylums had accelerated (from the late 1980s) and there was a growing concern how recently discharged patients would live in the community the potential risk they posed to the general public and the ability for the newly established community services to manage them (Rose, 1998).

The four main components of the CPA were described as:

- Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
- The formation of a care plan which identifies the health and social care required from a variety of providers;
- The appointment of a key worker to keep in close touch with the service user and to monitor and co-ordinate care; and
- Regular review and, where necessary, agreed changes to the care plan.

(Department of Health, 1990a).

The aim of this section is to develop the narrative of the regulatory state as a condition of possibility for the CPA and its evolution. A series of reforms occurred in mental health services in the late 1990s under the Blair administration, with Government discourses of “modernisation”. The evolution of the CPA represents these policy priorities, for example: “Modernising the Care Programme Approach” (DH, 1999), (see table 1, p.6).

These strategies have been conceptualised by governmentalisation theory in the sense that they influence the way professionals work, using techniques such as compliance monitoring and performance indicators. Commentators have remarked that the arena of mental health was an easier target of reform due to weaker or fragmented professional interest groups (6 and Peck 2004a). With the rise of the risk discourses related to mental illness and the failure of community care the Government had a mandate for reform.

6 and Peck (2004a) outline New Labour’s key commitments to New Public Management (see Table 4): inspection; “central standard setting; co-ordination and integration; earned autonomy as a compromise between centralism and decentralisation; an extended role of private capital; and e-government” (6 and Peck, 2004a p.6). The following discussion will focus on the CPA and inspection, central standard setting, joined-up working, and the role of information and

electronic government. Citizen’s obligations will be referred to in the section on consumerism and recovery at the end of this chapter.

Table 3: Key features of the “Modernising” reform regime in mental health (6 and Peck, 2004b).

Key feature:	Represented in mental health by:
Inspection (i.e. CPA as performance indicator)	Performance management of implementation of Framework standards; Commission for Health Improvement; National Institute for Clinical Excellence.
Central standard setting (i.e. to implement the CPA)	National Service Framework for Mental Health; NHS Plan.
Co-ordination and integration: “joined up government”	Patient level: CPA, integrated health and social care plans. Service level: joint commissioning and providing.
Earned autonomy	Foundation Trusts; “Traffic light” and “Star” system assessment of effectiveness of local implementation.
Private sector involvement	Extensive use of private sector providers to compensate for lack of NHS beds or for “specialist” patients. Private Finance Initiatives in small number of cases.
Citizen’s obligations	Explicit assertion of duty upon patients for responsibility with treatment regime supported by compulsory powers in new Mental Health Act proposals.

Access	Standards in Framework for access to primary care and for 24/7 access to crisis services and updated CPA.
Electronic government	Local information strategies; integrated electronic records across health and social services to have CPA section.

4.2.1 Inspection as a Means of Control

Inspection is a way of addressing the issue of responsibility in a de-centralised mental health system (see Table 3). Since the CPA was introduced there has been considerable change in the field of mental health care regulation. From 2000-2003 there was the Commission for Health Improvement (CHI); from 2003-2009 there was the Health Care Commission (HCC). Currently, mental health services are regulated by the Care Quality Commission (CQC) and Monitor. Largely, regulators monitor to what extent Government policies are being implemented. They do not evaluate or assess the quality or evidence base of the policies themselves. For example, it would not be within their remit to question the rationale of the CPA, or the CTO. Critics have observed that there is a tension between politicians and the regulators, which is that it is not in the politicians' interests to increase the autonomy and legitimacy of regulators (Hood and Scott, 2000). It has been questioned to what extent regulators such as the CQC are truly independent and therefore whether they are fit for purpose. The CPA is a particular construction of the business model of mental health service. For example, commissioners use evidence of CPA implementation as one of many "quality standards" by which to assess the performance of providers. Many service providers use the CPA as a quick and easy way of evaluating their own performance.

4.2.2 Central Standard Setting

The conceptualisation and implementation of the CPA has been directed by central Government through the provision of substantial guidance and specific standards for Trusts to follow (see Table 4). Standard 4 of the National Service Framework for Mental Health (1999, p.43) makes reference to how services should implement the CPA:

“All mental health service users on the Care Programme Approach (CPA) should:

- a. Receive care which optimizes engagement, anticipates or prevents a crisis, and reduces risk;
- b. Have a copy of a written care plan”.

4.2.3 Inter-Agency Working

In the late 1990s discourses of “joined-up working” and “co-operation” became means of remedying long-term problems in co-ordinating health and social care services (see Table 4). The National Service Framework (1999) required integration of the CPA in the NHS with local authorities’ care management processes (Department of Health, 1999a). The CPA acts as a form of structure where responsibilities are defined (e.g. who is the care co-ordinator). The aim is to reduce gaps in service provision and to reduce disputes of responsibility at the interface between services. This was demonstrated on practical level by developing accountancy practices such as pooled budgeting, or “joint commissioning”.

The CPA represents the division of labour between the multi-disciplinary team for example, the psychiatrist, the social worker, the community psychiatric nurse, the clinical psychologist and the occupational therapist. Since the introduction of the CPA, these expert roles have been merging to some extent. For example, risk assessment and management is a skill that is extended to include all those involved in mental health services, it cannot be located in one senior professional. Changes brought in under the 2007 Mental Health Act underline this merger for example the introduction of the “Approved Clinician” and the “Responsible Clinician” meant that these roles could be filled by a range of

mental health professionals, any one of whom has overall responsibility for a patient's care under the Mental Health Act so they have powers of deprivation of liberty. This replaces the functions previously performed by the Responsible Medical Officers (RMOs). This might suggest that there is a move away from profession-based roles to competence-based roles.

4.2.4 Electronic Government and Information Technology

As discussed in the previous chapter developments in information technology have helped facilitate the goals of the new public management. This has had a major effect on the introduction of the CPA as it allows care plans to be documented on a centralised electronic database which can be accessed by all professionals involved in the case. This may have had an important role in the way in which mental health care is constructed. The work of professionals is now closely recorded (by themselves) and monitored and inspected (through audit) to improve "quality". This might create an atmosphere of surveillance within services; possibly creating a sense of professional defensiveness:

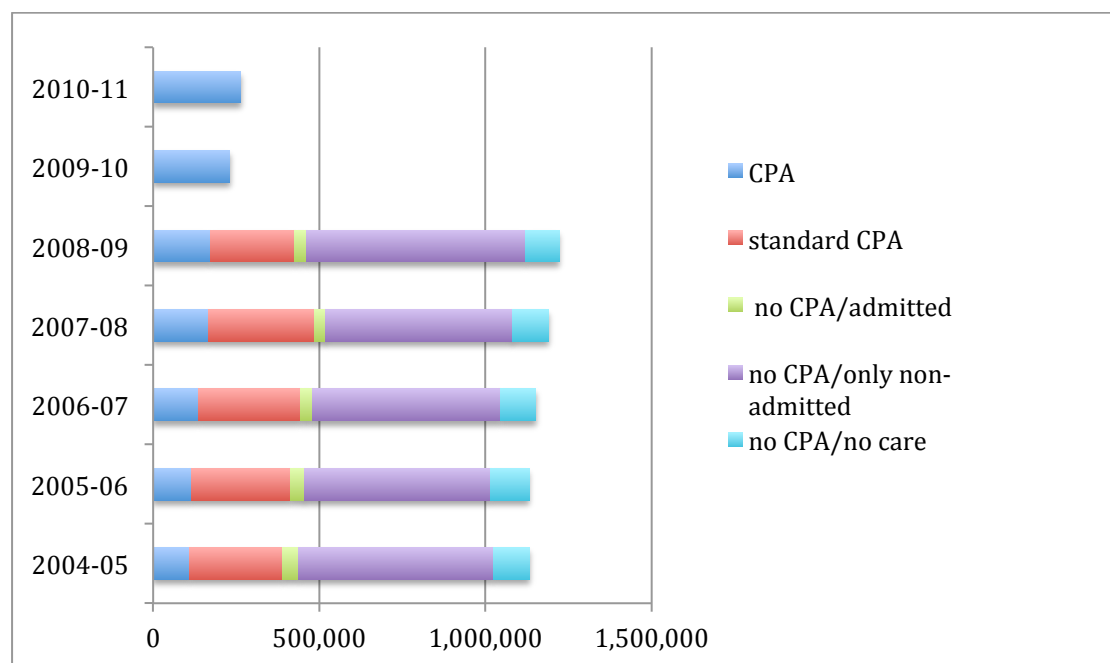
"Surveillance is not only of the patient by the professional but also of the professional themselves, existing in a panoptical space inhabited NHS managers, government ministers, inquiry teams, the media and so on. An effect of this is increasingly defensive and bureaucratic practice".

(Harper, 2004, p.18).

The CPA is included in the Mental Health Minimum Dataset (MHMDS). This is a Government programme initiated in 2003 to develop the collection of mental health data which can be used for management and planning purposes. The Healthcare Commission set a target for Trusts to collect this data on each service user's CPA level, date last seen and details of care co-ordinator. Performance was evaluated based upon the submission of this data from the Trusts (The Sainsbury Centre for Mental Health, 2005). This data provides the Government with a demographic summary of the mental health population, identified by the

CPA. Strategies can then be developed on how to better contain this population. Figure 2 below from the MHMDS shows that from 2008 the number of patients on CPA has reduced significantly because the “standard CPA” has been abolished. In 2008 60 per cent of patients did not have a CPA contrary to the 1999 Code of Practice to the Mental Health Act 1983, that it was a statutory obligation for services to provide all patients with a CPA (DH, 1999c). It is possible that the collection and publication of this data influenced the decision to abolish the “standard CPA” perhaps to increase the efficiency of services focusing on the high-need / high-risk patients. The next section will consider the emergence and influence of the risk discourse in mental health services.

Figure 2 Mental Health Minimum Dataset: Number of people on CPA 2003-11 (Health and Social Care Information Centre, 2011).



This section has discussed how the CPA has evolved with organisational reforms in the NHS in keeping with the culture of New Public Management established in the 1980s. For example, the use of new managerial strategies such as inspection, central standard setting, and information technology). As discussed in the previous chapter these reforms began in the 1980s, but their origins can be

traced back to the 1960s when statistical and monetarist techniques were introduced which displaced the role of corporate interest groups (e.g. BMA and the trade unions). The next section will discuss the rise to prominence of the risk discourse attributed to community care which may have influenced the way the CPA was used, and how it was reformed by Government policy.

4.3 Risk Discourses and Community Mental Health Services

By the early 1990s the risk discourse attributed to mentally ill patients was associated with the failure and neglect of community care system (Timmins & Brown, 1996). The growing strength of these discourses have been attributed to high profile risk incidents such as; the murder of Jonathan Zito by Christopher Clunis in 1992; the mauling of Ben Silcock by a lion at London Zoo in 1993; and the murder of Lin and Megan Russell by Michael Stone in 1996 (see Table 4, p.74).

Before exploring the emergence of the risk discourse related to community care it is important to consider that there have been longstanding associations between madness and danger over many years (Ion & Beer, 2003). In the 1950s the sense of danger was understood as an internal pathology which was hard to diagnose or explain, and was primarily located within the walls of the asylum. In the 1980s discourses of danger changed to become a range of different factors and were influenced by ideas of statistical probability and the possibility to predict unfortunate incidents by identifying a risk population (Rose, 1998). Robert Castel has discussed the shift in discourses from “dangerousness to risk” (Castel, 1991).

4.3.1 The Role of the Media

The media played a significant role in the early 1990s in developing the risk discourse for community care. Media reports of these high profile incidents were different from previous eras of reporting which have always contained stereotypical and sensationalist portrayals of the mentally ill. The change in the early 1990s came from the association with a failure of the community mental

health system and negligence and a lack of responsibility from professionals (Stark et al 2004).

The murder of Jonathan Zito by Christopher Clunis in 1991 was a watershed moment in the media coverage on the subject, as it seemed to be the first instance where social policy was implicated in such tragedies. Paterson (2006) suggests it was not until six months after the murder that such discourses emerged following an interview with Jonathan Zito's wife Jayne Zito who had experience working within the mental health system. In an interview with the Evening Standard she called for an inquiry into the government policy of community care and closure of the hospitals. She did not blame Christopher Clunis for the murder but directed responsibility towards the Government's policy for community care (Paterson, 2006). Here the discourse implies that Clunis was not morally responsible for his actions, that it was his illness, and the failure of services and professionals to protect him from himself. This will be expanded upon later, but it is suggestive of the manifestation of a system of blame (Douglas, 1992) whereby unfortunate incidents are recast as being preventable; therefore the professional becomes as culpable for the act as the actual perpetrator.

The emergence of the risk discourse for community care is demonstrated by Diana Rose's study (1998) which compared the media coverage of homicides related to mental illness in 1986 to a period in 1992. Although there were stories reporting on the violence committed by psychiatric patients in both years, only in 1992 did the stories focus on neglect as a result of the failure of community care. Rose identifies the "ideal narrative structure" as:

1. A tragic act, preferably random;
2. A culprit (nearly always male and often black) with a psychiatric history;
3. The opinion of an expert;
4. An analysis of the events leading up to the act, focusing on the individual's contact with mental health services, which functions as an explanation for the crime;

5. The explicit or implicit blame of the NHS, Social Services or the Secretary of State for Health.

(Rose, 1998, p.223).

The risk discourse for community care is further demonstrated in an article in The Guardian in 1992 where it was reported on the danger in discharging patients without the adequate community care, and that number of mentally ill people in recent years who have committed murder (Paterson, 2006). The risk discourse associated with failures of community services has endured over the past 20 years. This is demonstrated by the murder of Sally Hodges by psychiatric patient Nicola Edgington in 2011. Speaking to BBC News Marjorie Wallace the founder of the charity SANE (who will be discussed further in the next section) made the following statement:

"If the system cannot cope with the relatively few cases of people with mental illness and a history of violence, how can we prevent the stigma which blights the lives of so many thousands who suffer from mental illness and are never violent?"

(BBC News, 2013).

4.3.2 *"The Moral Entrepreneurs"*

As mentioned in the introduction it is important to consider expert knowledges which promote the need for a CPA. Interestingly, during this period new self-appointed experts emerged who were affiliated with charitable mental health organisations. They played a significant role in authenticating the risk discourse and attained influential positions and expert status such as Schizophrenia: A National Emergency (SANE) and the National Schizophrenia Fellowship (now Rethink). One of these new experts was Marjorie Wallace, a former journalist who founded SANE in 1986. She had been exposing the neglect of patients discharged from the large mental hospitals with a series of articles in the national

press criticising the closure of the psychiatric hospital, and making life worse for the patient (Rose, 1998). SANE used the high profile Zito murder case to promote its campaign for more hospital beds and tighter restrictions on discharge from hospital.

The Zito Trust mentioned earlier is another example of this new type of expert knowledge which attained a position of influence during the mid-1990s. The charity closed in 2008, in part due to a feeling that it had achieved what it originally established to do with the introduction of the 2007 Mental Health Act, which made it mandatory for mental health patients to have treatment if they were living in society outside of the hospital where they had received treatment. More recently, Julian Hendy a journalist, whose father was murdered by a psychiatric patient known to mental health services published an article in the Daily Telegraph, which evoked the risk discourse for community services with the headline; “Britain’s failing mental health system must change” (Hendy, 2012, p.14). Here he explicitly refers to poor care planning:

“These were basic aspects of mental health care that aren’t really that difficult or complicated – they included neglecting to plan care properly, carry out proper risk assessments, keep proper records and share them appropriately.”

“I think we need to open up a rational and balanced debate about mental health and violence in this country, which measures the effectiveness of current mental health care against the available resources”.

(Hendy, 2013, p.14).

4.3.3 Government Inquiries

Next, in tracing the emergence of the risk discourse related to community care, it is important to consider the role played by official government inquiries. In 1994 the Government introduced a requirement for official inquiries into all homicides perpetrated by psychiatric patients (Rogers and Pilgrim, 2001). These often

repeated the same themes and offered similar recommendations thus contributing towards the narrative of failure which aligned with the new experts. For example, the homicide inquiry into the care co-ordination of Christopher Clunis described several shortfalls of the community care system which had permitted insufficient monitoring and a lack of inter-agency communication (Ritchie and Lingham, 1994) (see Table 4). Also individual professionals were held responsible for failings of the system (Coid, 1994).

4.3.4 Government Interventions

The combination of media reporting, expert knowledges and official inquiries created a powerful discourse of risk; an atmosphere for something to be done. The CPA had already been introduced (in 1991) however these pervasive discourses of risk and blame created a sense of necessity and urgency for the effective implementation of the CPA across all national mental health services. The assessment of risk and risk management strategies were seen as central to the CPA process as a means of monitoring and controlling psychiatric patients in the community (DH, 1995). Shortly afterwards a new law, the Mental Health (Patients in the Community) Act was introduced in 1995, which led to the formal concept of risk assessment documentation and the introduction of supervision registers for high-risk patients being discharged from hospital. This was criticised at the time for being anti-therapeutic and restricting the civil rights of patients (Eastman, 1995). However, it was augmented by the 2007 Mental Health Act, with compulsory treatment in the community. The risk discourse is strengthened by high profile homicide cases (see Table 4 below), is influential on the public, and therefore risk management policies become politically lucrative. The next section will examine whether statistics on homicide are associated with psychiatric patients.

Table 4: High profile risk incidents 1990-2013

1991	CPA introduced.
1992	Christopher Clunis murders Jonathan Zito.
1992	Ben Silcock commits suicide by climbing into a lion enclosure at London Zoo.
1996	Michael Stone – convicted of the double murder of Lynn and Megan Russell.
2009	Psychiatric patient Nicola Edgington murders Sally Hodges.

4.3.5 Records of Homicide and Suicides Attributed to Psychiatric Patients

Taylor and Gunn (1999) reported that there has been little change in psychiatric patients committing homicide over a 38 year period, and a three per cent annual decline in their contribution to official statistics. Meehan et al. (2006) reported that 61 per cent of psychiatric patients who committed homicide were compliant with medication, and 60 per cent had an enhanced CPA. This might suggest that it is as important to attend to the social circumstances of psychiatric patients as it is to their medication compliance.

The emergence of the risk discourse has been supported by statistical surveys demonstrating the increase of homicides related to mental illness. For example, The National Confidential Inquiry into Suicide and Homicide (NCISH) (2009) reported an increase in homicides by people with mental illness from 54 in 1997 to 70 in 2005. A similar finding was reported for people with a diagnosis of schizophrenia, from 25 in 1997 to 46 in 2004. Evidence such as this, given in an emotive and risk infused context, might be highly influential on policy-making decisions. The most common risk is of suicide, for example in the UK in 2006; there were 4421 suicides; 3,350 of these were men and 1,071 were women (9 per cent were under 25, 41 per cent were aged between 25–44, 34 per cent were aged between 45-64, and 16 per cent were 65 and over) (NCISH, 2009).

However, this is at odds with a systemic review and meta-analysis that found homicide rates by people with schizophrenia are associated with rates of all

homicide (Large, 2009). This study suggests that both types of homicide have factors in common and psychiatric patients cannot necessarily be set apart. The discrepancy between the two studies is due to the use of different operational definitions. The NCISH was based on psychiatric reports for the court (NCISH, 2009), whereas Large et al. (2009) used court decisions of diminished responsibility. Therefore the NCISH had a lower threshold for inclusion.

Large et al (2008) also found that the rate of total homicides and the rate of homicides due to mental disorder both rose steadily until the mid-1970s, and from then there was a decrease in the rate of homicides attributed to mental disorder. These have declined to historically low levels, while other types of homicide (e.g. domestic) continued to rise (Large et al, 2008).

This underlines the importance of the risk discourse in mental health, that despite strong evidence to the contrary, psychiatric patients are perceived as being a threat to social order, and professionals and services are portrayed as failing in their duty to protect the public. The next section will investigate how the CPA subject is constructed in close relation to the risk discourses and to consider some of the consequences of this.

4.4. The CPA Subject

The aim of this section is to consider how the CPA subject is constructed, alongside the discourses of risk and consumerism. With the transition from “dangerousness to risk” (Castel, 1993) the task of mental health services is to regulate levels of deviance in a broad managerial fashion, with greater emphasis on thinking about the mentally ill in population. This is perhaps reflected with broad and standardised strategies such as the CPA that can identify, classify and remove the risk presented by psychiatric populations. This creates a new and different task for the mental health professional, running alongside their traditional roles of diagnosis and treatment (which were the main focus of treatment in the asylum). Therefore, in response from the transition from deinstitutionalization to community care patients are thought about in new ways:

“Risk is governed via a heterogenous network of interactive actors, institutions, knowledges and practices. Information about diverse risks is collected and analysed...Through these never-ceasing efforts risk is problematised, rendered calculable and governable. So too through these efforts, particular social groups or populations are identified as ‘at risk’ or ‘high risk’, requiring particular forms of knowledges and interventions”

(Lupton, 1999, p.87).

The CPA can be conceptualised as a site where knowledge is produced and the identity of the psychiatric patient is created (Soyland, 1994). This process begins with an assessment, which is used to determine which level of care would be most appropriate. Initially, some services had three levels of CPA (high, medium and low). In 1999 under “Modernising the CPA” this changed to “standard” (low risk, and maintain contact with services), and “enhanced” (high risk, and disengage from services). It is intended that this professional judgment is then communicated to the patient and referrer. As of 2008, following guidance in “Refocusing the CPA”, this term is only to be used for patients meeting the criteria for the “enhanced” category which has been termed the “(new)CPA”. So the risk subject is now synonymous with the CPA, with lower risk subject receiving other strategies which place greater emphasis on self governance.

This could be seen as an attempt by government to streamline the CPA process. Originally intended for all service users referred to secondary care, it is now only used for those who meet the highest risk criteria. This may have been influenced in part by the over subscription of services. The characteristics of the type of person who might meet criteria for the “(new)CPA” are described as patients with a history of violence, the homeless, substance misusers, and parents (DH, 2008 p. 18). This group are deemed likely to disengage from services and not to be compliant with their medication. The problematisation of people on the margins of society (such as psychiatric patients, drug dealers, the homeless, and paedophiles) creates a space for the work of experts, social enterprises, and service user groups (Rose, 1998). The CPA reflects the need to identify and classify the risk of these persons, and to provide them with a range of services to

reduce their risk. This relatively modern phenomenon of management, might have implications for how the patient-practitioner relationship is constructed which will be discussed next.

One of the consequences of the construction of the CPA subject is that risk management becomes prioritised over other aspects of care, as the primary duty of the professional is to protect the public. Castel (1991) suggests that techniques of control such as the CPA do not prioritise therapeutic involvement with the patient, preferring strategies that attempt to reduce their perceived risk. In this regard, Simpson et al (2003) have described how the CPA does not focus on the therapeutic relationship between care co-ordinator and patient, despite evidence that this is a potential curative factor. This is not contained in the guidance, and aspects of care might actually conflict with the care co-ordinator's responsibilities, of assessment, monitoring, co-ordination and administration, with a secondary role of providing therapeutic support. This suggests that mental health work has been reconfigured around expectations for risk management, and a litigious environment.

“Most people subject to the CPA are likely to require supportive counseling to some degree. Key workers and care managers are likely to provide some of this as a normal part of co-ordinating people's care plans, and acting as their first point of contact”

(Department of Health, 1994, p.119).

This describes a counselling role, however the emphasis seems to be for co-ordination. Castel (1991) has commented that in services where monitoring risk predominates, the effect is that “there is no longer a subject”. This changes the role of the “community experts” in the early days of the welfare state (see section 2.5.2, p. 40) where perhaps there was greater possibility to offer care and support alongside the more punitive aspects of the role.

This section has described how the subjectivity of the psychiatric patient has evolved with the grounding of community care; which implicitly prioritises the

protection of the public over the care of the patient. And care (such as medication compliance) is increasingly being regarded as in aid of risk management. However, despite the risk discourse, the CPA is also associated with the discourse of consumerism and empowerment, these conflict with the risk discourse and might be used by services in a tokenistic fashion when applied to the CPA group. It is questionable to what extent the authorities wish to reform this population; preferring a strategy of assessment, monitoring, and harm reduction. However it is important to consider the discourse of consumerism which might have greater applicability for the non-CPA group.

4.4.1 Governing Through Fear

The CPA might represent a government response to a longstanding fear of mental illness in the public domain. Rather than asking questions about the meaning of madness and the human condition it becomes preferable to look for certainties. This leads onto a consideration of the role of the high-risk psychiatric population providing a social function. The feared other, might function in the process of ways of self-governance, that prevents citizens stepping out of the safe and ideal community. Following Nietzsche's argument in *Genealogy of Morals* (Nietzsche, 1969) shocking incidents such as the murder of Jonathan Zito provoke a sense of anger or rage that eclipses other responses such as the grief, pain, or fear. The feeling of anger creates a subject who can be held responsible, and seeks to create a site of revenge to remedy the pain (e.g. seeking meaning through the blame of community services) (Rose, 1998).

Rose (1998) suggests that this adds a good conscience to claims for justice and control in the name of those innocent victims. It might also enable people to feel morally virtuous by the mere existence of the other. The construction of the mentally ill "monster", sits opposite to the utopian late modern community, where families are not disturbed by undesirable deviations. The ideal community is allowed to continue uninterrupted with its goals towards contentment. However the presence of these gross, predatory monsters can be quickly brought to one's attention and with ease:

“Madness comes to be emblematic of the threat posed to ‘the community’ by a permanently marginal, excluded, outcast and largely unreformable sector who require management”.

(Rose, 1998, p. 192).

The CPA might in some implicit manner, by its very act of documentation, construct this particular identity of the high-risk outsider, with the hope of controlling it on behalf of the protected majority. Douglas (1992) suggests that in late modern secular society the physical body of the person becomes more important than the afterlife. As a result, society conceives the deaths of young people or children as the ultimate scandal. A tragic death, or any death for that matter cannot be seen as a mere accident; rather someone must be held responsible. Perhaps modern society lacks the vocabulary for thinking outside the risk discourse. Instead, it seems preferable to locate the pain within an identified population of “monsters” (and their supposed custodians).

This section has discussed how the risk discourse can restrict the level of thinking about mental illness. The risk discourse seems to provoke strong emotions such as outrage and fear which provides a compelling narrative to late modern society. Indeed, it may not be in the interests of governments to help professionals work together to challenge the risk discourse. Following the trends of the last chapter governments have developed administrative strategies such as the audit that serve to challenge the power of collective bodies and disseminate a culture of competition at the heart of the public sector.

4.4.2 The CPA Subject as Consumer

Alongside discourses of risk the CPA also represents discourses of consumerism and empowerment. This reflects the contradiction between care and control; between the autonomy of the patient and the obligations of the care co-ordinator to protect the public at large.

The previous chapter discussed the emergence of the mental health consumer (aligned to social norms of individual responsibility and self fulfillment) and how problems arise when the consumer and the provider disagree over the form of treatment. If a patient is forced to have treatment it is questionable to what extent this type of care can ever be conceived as shared. Indeed, this most obvious power situation, the very existence of compulsory treatment, questions the appropriateness of shared care planning in the first place.

Paternalistic psychiatry of the post-Second World War era, as depicted by the ward round, may have been disciplinary in the sense that the powerful doctor diagnosed and treated. This has mutated into a more subtle means of social control attuned to social norms of individual responsibility and self-fulfillment, whereby free, responsible citizens govern themselves, separate from the state, for example by investing in their own private insurance schemes.

The identification of the high-risk psychiatric patient and the “productive consumer” do not seem to be compatible. The introduction of concepts to the CPA population do not address the inherent contradiction between care and control. In this way, the affinity between the risk and consumerism, might not be that the risk population will be transformed into the consumer. Rather that there is a need for a permanent risk population, the presence of a monster, to serve the function to legitimate continuous, and subtle modes of social control (such as video surveillance of community spaces) and provide meaning when terrible tragedies occur. This is familiar to the previous discussion on “governing through fear” (p. 78) and Rose’s conceptualisation of “governing through madness” (Rose, 1998, p. 190). Next the discussion will consider one of the most influential strands of the consumerist discourse: “recovery”.

In recent years the concept of “recovery” has been incorporated into the discourses of mental health services. In an effort to demonstrate improvements in patient experience some trusts have introduced recovery goals into the CPA (London Strategic Health Authority, 2010). The term recovery has been defined as, one of the most cited definitions of Recovery comes from Anthony (1993, p.11):

“a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles...a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life”.

The emphasis of recovery is upon the individual, as Harper and Speed (2012, p.12) suggest “rather than effecting social change, the marginalised other is required to change within their own life”. Slade (2009) makes a differentiation between “personal recovery” and “clinical recovery”. The latter involves reducing symptoms – a similar goal of the neuroleptic medication, and therefore falls within the remit of the expert knowledge of the professional. The former involves the expert lived experience of the patient. Harper and Speed (2012) suggest that this is a discursive device that strengthens the concept of clinical recovery: preventing the concept of clinical recovery from being critically examined or challenged.

One of the personal recovery tasks proposed by Slade (2009) is for “self management” of the mental illness. This resonates with the social norms of individual responsibility and self-fulfillment rather than collective or State responsibility. This connects with the idea of “governing at a distance” (Miller and Rose, 1992, p.8) whereby the State has less direct involvement in the lives of its citizens as they become self-governing entrepreneurs. While the projects of recovery have been applied to the CPA subject they may be more applicable for patients who have not been categorised as “high risk”, who can connect with the broader neoliberal and therapeutic discourses, which will be considered next. This might link to the feature of “citizen’s obligations” under the “Modernisation” reform regime under the Blair Government (see Table 3 p.64). This placed the duty upon patients for their responsibility with the treatment regime which would be enforced by the new powers in the Mental Health Act, 2007.

4.5 Conclusion

This chapter has built on the narrative of the previous two chapters, that as an administrative technology, the CPA is part of the bureaucratic network of the welfare state. This network was influenced by a management philosophy in the 1980s (New Public Management) which has shaped the way mental health

services are constructed in the present day. For example, central standard setting, joined up working, and information technology (6 and Peck, 2004). As a component of the “regulatory state” the CPA has also been influenced by a powerful risk discourse related to the failings of community care which gained in momentum from 1990 onwards (following high profile homicide inquiries). This has been implicated with creating a professional culture of blame, fear and individual responsibility rather than a collective mentality in mental health services (Douglas, 1992). The chapter has also discussed the implications the CPA might have on how psychiatric patients are constructed and how this might be different from the past. It raises a concern that risk thinking, as represented by the CPA, has come to eclipse other considerations such as what kind of society we live in, and how can we work and live together?

CHAPTER 5: OVERVIEW AND EVALUATION

5.1 Thesis Overview and Discoveries

This chapter will provide an overview of the study and what has been discovered from a genealogy of the Care Programme Approach (CPA). The second part of the chapter will evaluate the study, discuss its limitations, and consider its implications for policy, training, research and practice. First it will refer back to the research questions which will inform the following discussion:

1. Where does the CPA come from in recent history and what are its underlying assumptions?
2. What do these assumptions tell us a.) about how mental health is constructed and b) about how the work of mental health services is constructed and c.) how have these constructions changed over time?

Chapter one provided a description of policy documentation which demonstrated how over time the CPA has become increasingly focused on patients deemed to be severely mentally ill. This was seen in the context of developments in the Mental Health Act 2007 that placed tighter restrictions on this population when they are discharged from hospital. It highlighted the emphasis on shared-care planning in the CPA. This suggested there is a contradiction in the constructions of mental health care planning, between care and control. Finally it discussed studies evaluating the CPA which helped illuminate the problem from both a professional and patient perspective. In genealogical terms this initial review mapped out the problem in the present so that the following chapters could begin a process exploring its conditions of possibility.

Chapter two (1948-1979) described the origins and evolution of the welfare state following World War II, the beginning of the modernisation of the NHS, the beginning of de-institutionalisation, and discourses of taboo and dangerousness related to mental illness. This argued that the welfare state established a vast new bureaucratic infrastructure and administrative strategies. The welfare state

was based upon ideas of collectivity and solidarity which provided the conditions necessary for reforms of New Public Management in the 1980. During this time mental health was perceived by the public as something to be afraid of and to be kept at a distance, while the service provision was still tied to the Victorian mental hospital. Mental health services were constructed very differently during this period to when the CPA emerged in 1991. However some pivotal themes were in gestation or initiated during this period (e.g. de-institutionalisation, and NHS management reform) that would resonate throughout the study.

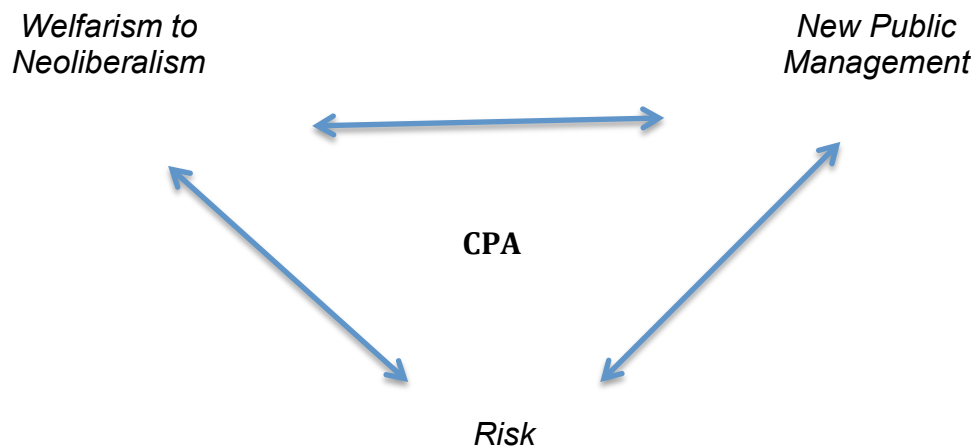
Chapter three (1979-1990) discussed the dominance of the political philosophy of neoliberalism in the UK, which established a New Public Management (NPM) culture in the NHS (see Figure 1). Also it discussed the gaining momentum of deinstitutionalisation / community care, and the emergence of discourses of risk and consumerism related to mental health.

The CPA would be introduced into this new management culture in 1991. During the 1980s the government developed strategies to increase their power over professional interest groups such as the BMA and the trade unions. One of the key ways they addressed this was to implement NPM strategies utilising the existing bureaucratic welfare infrastructure; channelling through mechanisms of control such as performance indicators, and compliance monitoring. NPM would become deeply embedded into the culture of the NHS (in which the CPA would play a prominent role).

Chapter four (1990 – present day) discussed the arrival of the CPA at the same time the emergence of a powerful risk discourse related to the failure of community services. It explored how community care has been approached by authorities in relation to the use of NPM regulation strategies such as central standard setting and inspection (see figure 1). The CPA was conceptualised as a technology of power (i.e. as a risk management strategy of psychiatric patients, and an organisational public management strategy of professionals). In relation to risk management, the CPA could represent the reification of the discourses of risk, into an entity that is used and talked about by professionals to control their behaviour and how they think and relate to their patients. This might influence the priority of team meetings which might become explicitly or implicitly influenced by

the risk discourse. Their 'goodness' as a professional may be increasingly judged by their compliance with administrative strategies of control. Service reform strategies in recent years, such as the consumerist discourse, exist alongside increasingly authoritarian policies such as the CTO.

Figure 2 Establishing the Conditions of Possibility for the CPA



The arrows in the diagram indicate that the three conditions of possibility for the CPA are inter-related contingencies that have influenced one another over time (Kendall and Wickham, 1999). For example it has been suggested that the presence of risk discourses, promote a blame culture (Douglas, 1992) which might shift responsibility from the collective to the individual. The political philosophy of neoliberalism (on which the NPM strategies are influenced) is a philosophy of individual rights and responsibilities. Thus reinforcing the position of seeking individual rather than whole system approaches to problems.

5.2 Evaluation

The history of the CPA presented in this study, as a genealogy, is an interpretational one. It has erred away from an exhaustive historical reconstruction, and has at times eschewed historical realism, in favour of considering how mental health has been constructed over time. The intention of this has been to disrupt knowledge that is taken for granted. Therefore evaluative concepts derived from positivist science such as reliability, validity, and

generalizability are not appropriate for this type of research. However some adapted criteria have been developed for qualitative research which consider the contribution the credibility and rigour of research (Spencer and Ritchie, 2012). Although historical analysis might seem unfamiliar, and to some perhaps irrelevant to Clinical Psychology, it is an accepted method within the discipline of Psychology (e.g. Bunn, 2012).

5.2.1 Contribution

The study may have value to government policy makers; to the practice of mental health care; and to the professionals and patients involved in the mental health system. The historical approach might provide some perspective to current problems faced by services, and highlight how dominant forms of knowledge (e.g. the need for risk management and NPM strategies) have become so deeply permeated into the culture of the NHS that there seems to be no other way of thinking. This might create a restrictive environment for professionals and patients to solve problems themselves. The aim has been to develop a narrative that might be considered to be politically and clinically helpful, and from which new ideas can emerge.

5.2.2 Credibility

To evaluate the credibility and plausibility of the analysis three methods were used. First, discussions with my supervisor allowed ideas to be tested out prior to them being included. Second, some considerable time prior to writing the study was spent familiarising myself with the conceptual material from Michael Foucault (1977), and Foucauldian scholars such as Nikolas Rose and Peter Miller (1990, 1992). Key texts such were used throughout to test the credibility and plausibility of the analysis. Finally, I participated in a peer group, with those using a similar methodology, this allowed testing out the concepts of the study.

5.2.3 Rigour

The study has attempted to apply an overarching requirement of academic rigour to the research questions, for appropriate decision-making and thoroughness. For example following an approach described by C.Wright Mills (1959) I have

kept a file of notes over the past two years which has contained a combination of theoretical and empirical material, and has attempted some systematic reflection on the process, which has integrated aspects of my working life as a trainee clinical psychologist. It is hoped that other researchers familiar with the genealogical method would be able to identify the same concepts used in the study, or who might even assign the same concepts. However, it is also expected that there would be differences between researchers conducting the same study with the same methodology. Therefore it is possible that another researcher using the same method could produce an entirely different study. Perhaps reliability (rather than in its positivist definition) could be viewed in terms of the reflexivity of the researcher which will be discussed next.

5.2.4 Reflexivity

This section will consider how the researcher has been implicated in the research process both as a person and a researcher. As Wright Mills (1959, p.216) suggests; “you must learn to use your life experience in your intellectual work”.

Personal Reflexivity

As discussed in the introduction, the idea for this study came from an announcement in a team meeting whilst working as a trainee clinical psychologist on placement at a community mental health team. It is important to acknowledge that this announcement resonated strongly with me. This was in part due to my conversations with a vibrant team who were not afraid to critically question policy directives that were handed down to them. This was also during a time of service cuts due to the Government’s austerity measures which affected those employed by the Local Authority. This may have created an emotive atmosphere in the team which I may have influenced me and my decision to initiate the study and to orientate it towards an analysis of power.

Epistemological and Methodological Reflexivity

A different methodology such as Grounded Theory (Glaser and Strauss, 1967) could have been used which would have fitted with the “bottom up” perspective that initiated the study. This would have identified points from a selection of the CPA literature, grouping them into categories and forming a reversed hypothesis or theory. This approach may have offered a more systematised way of going about the research and may have been more structured for the researcher. This however might have not have given such a prominent role to power which was important to the problem. However such an approach may have been illuminating if it had been based on interviews with members of the team where I was on placement. A more realist analysis might have identified some of the more positive aspects of the CPA such as a valid attempt to meet the needs of patients, and that it is a problem of ineffective management that has limited its success in the area.

5.3 Implications

5.3.1 Government Policy Implications

The study has tried to illuminate the extent to which the CPA is an administrative solution to a social problem, and a product of a particular approach to management that was developed in the 1980s. In 2013 Robert Francis QC chaired an investigation into scandals at the Mid Staffordshire NHS Trust. He concluded that the Trust was preoccupied with targets and processes and lost sight of its responsibility to provide care (Mid Staffordshire NHS Foundation Trust, 2013). In response to systemic failures of NHS management the Government has issued guidance on increasing levels of “compassion in practice” (e.g. DH, 2012). While “compassion in practice” is a noble cause it does not directly address systemic failures of the public management philosophy and techniques such as the use of performance indicators, and compliance monitoring (which the CPA is involved in). Could there be any alternatives to non-administrative care planning? The reforms to the NHS in the past thirty years

have been characterized by a ridged adherence to the NPM (e.g. Table 3, p. 64-65). Simon Jenkins described the situation in 2007:

“To every activity is attached a pecuniary value and thus a performance. To every performance is attached a target and to every target a league table. The targets may seem to be guided by what people say they want in focus groups, but in reality they are ‘negotiated’ by power blocs within public services. Their enforcement depends on matrices of budgets, feedbacks and incentives, covered by quasi-contracts and internal pricing systems.”

As this study has argued the philosophy of the New Public Management limits the capacity for services to evolve as it restricts the thinking of professionals involved. It might be possible for the current regime to mutate, adopting a more systemic approach with different assumptions about the workforce: such as professionals are motivated by pride in their work more than money, they want to serve, and are capable of using their own initiative and problem solving (Seddon, 2009). This would not deny the existence and need for authority however it might hold different assumptions about the people it governs. How could teams be organised differently so that the CPA becomes more integrated into mental health work?

5.3.2 Clinical Training Implications

It might be useful to introduce more of an historical and sociological perspective into clinical psychology training courses. David Pilgrim (2010, p.11) has highlighted that amongst clinical psychology trainees there is a “common ignorance about history and society. In other words psychological reductionism and the clinical gaze pre-empt reflexivity for psychology practitioners” It might be useful for trainees to be able to develop skills in historical analysis in addition to their more traditional skills base. This might help trainees be able to question the taken for granted assumptions about the discipline of psychology and to gain a broader perspective on the contexts in which they work.

5.3.3 Research Implications

It may be possible to extend the lines of investigation of this thesis. First, the CPA could be counter-productive to risk minimisation in mental health services through the possible negligence of patient meaning and engagement. Might professionals fail to listen to patients if their prime concern is completing the CPA form and adhering to its checklist of requirements? Second, it seems reasonable to ask the question: where is the “care” in the CPA? In this sense has the CPA (as an aspect of “technology of self”) been realised more successfully with professionals than with patients? Future research into the CPA and mental health services might benefit from investigating NHS professionals’ views on “care” and the CPA by analysing transcribed interview data. Finally, it might be possible to promote genealogical and qualitative research methods within mental health services, alongside more traditional forms of service development research.

5.4 Limitations

The study is text based and it has not generated evidence through interviews. It may have been possible to obtain oral histories from ex-patients or staff from different time periods. This could have provided some greater context to the analysis of documentary evidence. However it has been noted that obtaining oral histories can be difficult and problematic. Also the genealogy is an interpretational history, and it has not involved an exhaustive historical reconstruction. The study covered a time-frame of nearly seventy years which has meant that it has had to be selective of its material, a more in-depth analysis might require a shorter time-frame.

5.5 Concluding thoughts

The CPA as an administrative solution to a social problem might restrict professionals and patients from perceiving, thinking, or working beyond a preconditioned capacity. It is understandable, within the current management paradigm for a kind of “automisation” through hope, fear and repetition, and a narrowing of perceptions of what mental health “work” involves. Indeed it might be the ambition of the Government and/or mental health services to find

certainties when there are none to be found. This study might well ask how can mental health teams tolerate the confusion and fear of not being able to help (or control) a patient? Perhaps the answer is in the not knowing. Keats (1817) coined a phrase “negative capability”, which describes the capacity for human beings to be able to move out of and revise their contexts, free from epistemological restrictions:

“I mean Negative Capability, that is, when a man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason”.

(Keats, 1817, p. 193).

Our current forms of thinking and acting appear to be poor solutions to the problems that confront us. This study has attempted to identify our current forms of thinking related to their context with the view that it is important to illuminate, and to examine them. This might create an opportunity for an alternative mode of thinking to emerge.

“We are faced with a breakdown of general social order and human values that threatens stability throughout the world. Existing knowledge cannot meet this challenge. Something much deeper is needed, a completely new approach. I am suggesting that the very means by which we try to solve our problems is the problem. The source of our problems is within the structure of thought itself. This may seem strange because our culture prides itself on thought being its highest achievement.”

(Bohm, 1981).

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APPENDIX A

Example of a CPA Assessment Form (extracted from Allen, 2004)

CPA ASSESSMENT FORM

Person's Name:

Assessment start date:

Assessment completed date:

Person's view (of Referral):

Carer's View (of Referral):

Current Mental Health Situation/Professional Network:

Recent events leading to this assessment:

Date of most recent referral:

If in hospital – ward and date admitted:

Other significant contacts:

Other Mental Health Professionals involved/current services

Other professional views:

Past Mental Health (Psychiatric) History: (incl. treatment)

Previous services:

Forensic History (to include all court convictions and police cautions)

Factual details of Abuse/Neglect

Family History:

Personal & Social History:

Ethnic/Cultural/Religious consideration

Present situation

Education

Employment

Environment

Previous Medical History:

Current Physical Issues (Please include allergies):

Healthcare needs

Personal care

Mobility

Current Mental Health Treatment (incl. medication):

Tobacco, Alcohol, and non-prescribed drug use:

Substance misuse

Outline of drug/alcohol history

Present alcohol/drug use

Current Social Circumstances:

Present location (if not home address)

Advocacy

Financial circumstances

Home circumstances

Housing

Leisure/Social

Legal Issues

Personal goals

Independent Living Skills:

Current Mental State:

Formulation/Summary:

Checklist of Needs (this section is optional)

(only tick needs identified, specify how these affect the Service User/Patient and include their views and their carers' views)

Daily Living Skill Issues

Description of Identified Need/s

- Budgeting
- Cleaning/Laundry
- Shopping/Cooking
- Ability to use

Public Transport

- | | |
|---|----------------------------------|
| <input type="checkbox"/> Other | Description of Identified Need/s |
| Physical Health Issues | |
| <input type="checkbox"/> General Health | |
| <input type="checkbox"/> Cleaning/Laundry | |
| <input type="checkbox"/> Shopping/Cooking | |
| <input type="checkbox"/> Ability to use
Public Transport | |
| <input type="checkbox"/> Other | |

Accommodation Issues	Description of Identified Need/s
----------------------	----------------------------------

- Levels of Support
- Environmental
- Conditions
- Local Relationships
- Security of Tenure
- Access to Facilities
- Other

Personal Care Issues	Description of Identified Need/s
----------------------	----------------------------------

- Hygiene
- Clothing
- Diet
- Medication
- Other

Financial-related Needs	Description of Identified Need/s
-------------------------	----------------------------------

- Benefits etc.
- Debts

Other

Current dependants (If ANY children – this box must be completed)
(family, children, pets etc.)

Name (and age/DoB) Relationship Dependence and Support Issues

Are Social Services Eligibility Criteria met? Yes No

Any Identified Gap in Service Description of Identified Gap and who is informed

Carer's Assessment offered to the Principal Carer? – Yes / No.

Carer's Assessment completed? – Yes / No (if No state why)

Date Assessment completed:

CPA Level Standard Enhanced Not Accepted for CPA

Social Services Assessment Outcome Code

Reason for 'Not Accepted for CPA', and summary of action to be taken:

Has the Person contributed to this assessment? – Yes / No (if 'No' please give details)

Has the Person seen this assessment? – Yes / No (If 'No' please give details)

Has the Person agreed with this assessment – Yes / No (if 'No' please give details)

Person agrees that this assessment can be shared with their Carer/Relative – Yes / No (If 'No' please give details)

Has the Person been given information about PALS – Yes/No

Any Other Relevant Information:

Name/s of person/s contributing Signature/s Job Title and Base Date to this Assessment

Signature of the Person being assessed

Date:

APPENDIX B

A corpus of documents that the genealogy was based upon.

1957	The Percy Report. Royal Commission on the law relating to mental illness and mental deficiency 1954-1957.
1959	The Mental Health Act.
1962	White Paper: "The Hospital Plan".
1975	White Paper: "Better Services for the Mentally Ill".
1983	Mental Health Act.
1983	Green Paper (1 st Griffiths Report): "NHS Management Inquiry Report".
1986	Audit Commission Report: "Making a reality of community care".
1987	The Mental Health Act Commission Second Biennial Report: 1985-1987.
1988	The report of the committee of inquiry into the care and aftercare of Miss Sharon Campbell. Chairman John Spokes.
1988	Green Paper (2 nd Griffiths Report): "Community Care – Agenda for Action".
1989	White Paper: "Caring for People - Community Care in the next Decade and Beyond".
1990	White Paper: "The Care Programme Approach".
1990	NHS and Community Care Act.
1993	Code of practice to the Mental Health Act 1983.
1994	The Report into the Inquiry into the care and treatment of Christopher Clunis.

1995	White Paper: "Building Bridges".
1995	Mental Health (Patients in the Community) Act.
1999	White Paper: " The National Service Framework for Mental Health".
1999	Code of practice to the Mental Health Act, 1983.
1999	Green Paper: "Modernising the Care Programme Approach – A Policy Booklet".
2007	The Mental Health Act.
2008	Green Paper: "Refocusing the Care Programme Approach".