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Choice in mental health: myths and possibilities†

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Abstract The government in England and Wales is promoting policies and initiatives to offer patients choice across all healthcare specialties. This has raised concerns in mental healthcare, particularly if the physical healthcare model of implementation is imposed. However, the 'choice agenda' is an opportunity for mental health services to be innovative and act as beacons to other disciplines in healthcare. The south-east London programme introducing choice in mental health services is offered as an example here. There already exists an 'ethos of choice' within mental health services, but current practices may require a focused approach and structuring to fit in with national policy. This also might be necessary to influence policy makers to take a different perspective on choice in mental health. The principle of choice goes hand in hand with the drive towards greater social inclusion for people with mental health problems.

Creating a Patient-Led NHS (Department of Health & National Health Service, 2005) reaffirmed the strategic aim of the National Health Service (NHS) to be patient centred, making it clear that the old tradition of 'doing to patients' was no longer acceptable. Instead, the fundamental relationship between patient and clinician, and equally between patients and the NHS writ large, is to be based on partnership. Improving choice is at the heart of the government's plans to make partnerships between patients, clinicians and the NHS work (Department of Health, 2003).

In the run up to the general election in 2001, the Labour Party promised to give patients more choice in the health service (Labour Party, 2001). Later, in July 2003 John Reid, the then Secretary of State for Health, promised that the 'choice agenda' would turn the traditional, doctor-centred health service inside out, arguing that greater choice will help to reduce health inequalities (Reid, 2003). The Prime Minister Tony Blair also presented consumer choice as a means of empowering people and achieving greater equality in the health service (Rankin, 2005). Jennifer Rankin points out that choice goes beyond 'voice' mechanisms such as surveys and consultations and is more specific than 'personalisation' and the all-embracing concept of 'modernisation', although it is undoubtedly part of both these agendas.

In practical terms, choice in NHS primary care and acute physical care has been translated as greater consumer choice and more convenience for the patient, what we might call the 'where and when' approach. This has put choice on the agenda in healthcare, but, as we will argue throughout this article, it has limitations: critically for mental health services it does not address 'how' choice should be implemented. 'How' means how service users are informed about choice, how power and dialogue about choices are shared between professionals and users, what choices there are for care, treatment and life outside of the care setting. These issues are, of course, relevant to physical healthcare too, where patients are not routinely offered choices in medications, types of surgery, after-care or therapies. At the moment, the dominance of the issue of long waiting lists has focused the choice agenda in physical healthcare on the 'where and when', but as lists reduce, it can be anticipated that people will start asking for more choices – choices we are already exploring in mental health services.

Users and carers are calling for more choice and involvement in health service planning and delivery. There is growing consensus that people should be informed about, and able to influence, decisions regarding their own healthcare (Charles *et al*, 2000;

†For a commentary on this article see pp. 68–70, this issue.

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Entwistle, 2000). Research shows consistently that users want services shaped to fit with their lives: on average, 80–90% want choice and the majority of those who are offered it view the experience as positive and valuable (Department of Health, 2006). The NHS has responded to these findings with various initiatives and measures, including giving access to a wider range of primary care services, for example by setting up 'walk-in centres'.

Improving choice in primary and acute physical care is now well underway. The focus has been on the 'choose and book' initiative, where patients are able to choose between four or five different service providers and book appointment times that suit them (Department of Health, 2004; http://www.nhs.uk/England/Choice). The choice agenda in primary and acute physical healthcare is underpinned by new financial incentives such as 'payment by results'‡ and 'practice-based commissioning'. Thus, essentially the choice agenda rests entirely on the twin pillars of competition and plurality of provision.

Choice and mental health

Most of us have concerns about how the choice agenda will fit in with mental health services. The obvious question that arises is whether choice can be implemented in these complex and highly individualised services. The rigidity and consumerist approach of aspects of the choice agenda in physical care sit uncomfortably with many mental health service users, carers and professionals. The focus on getting the fastest care possible, manoeuvring around waiting lists by travelling to other hospitals for treatment, is in direct conflict with the ethos of modern mental health services. These services aim to break down stigma and reconnect people with their families, local communities and opportunities such as employment and social activities. If the current ideology of choice forces the local hospital to close or disrupts established services then patients will soon begin to disagree with it (Timmins, 2005). A sense of unease prevails and already we are witnessing the emergence of several myths regarding the concept of choice in mental health (Box 1). These might, if not countered with positive experiences and evidence, undermine what could be a significant opportunity for service users, carers and professionals.

In fact, we believe at present there is greater scope for creating truly meaningful partnerships and choices in mental healthcare than in primary or acute physical care services. There is also a tradition and wealth of good practice from which those services could learn. Here we hope to demystify the myths and reveal the realities of the opportunities that the choice agenda offers by highlighting the Care Services Improvement Partnership's new national framework for choice in mental healthcare (http://www.mhchoice.csip.org.uk) and sharing learning from pilot work in south-east London. We aim to raise readers' awareness of the issue of choice and encourage further discussion.

Box 1 Myths about choice in mental health

- People with mental health problems can't or don't want to make choices
- Service providers are unable to offer choices in mental health
- Professionals are widely sceptical and opposed to it
- This is all about opening up the mental health market to private providers
- The acute services model will be imposed on mental health services, which will completely destabilise mental health services and fragment community mental health teams
- This is another branding strategy for a better corporate outlook for the NHS
- This is change for the sake of change

Improving choice

In 2003 an expert taskforce appointed by the Department of Health published detailed recommendations on extending choice in mental healthcare. A year later, in a speech to the Sainsbury Centre for Mental Health and Warwick Medical School, Rosie Winterton, the Minister of State for Health with the lead for policy on mental health services, stated that 'the choice agenda ... applies as much to mental health services as anywhere else' (Winterton, 2004). However, Forrest (2004) observed that, despite these recommendations, by the end of 2004 little had changed and the government had been reticent in making the links between choice and mental health. For example, there were (and still are) no public-sector agreement (PSA) targets.

This continuing reticence does raise concerns, but it is also a relief. Concerns because, as Cliff Prior, former Chief Executive of Rethink, said 'People with mental health problems have been stigmatised, subject to poor practice or not taken seriously' (Prior, 2003). Relief though, as this is an opportunity for mental health service providers to be creative and

‡Payment by results is discussed on pp. 3–6 and 7–9, this issue. Ed.

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take a unique and 'bottom-up' developmental approach to delivering choice. Such an approach may prove to be more effective as it could bring about cultural change in a more sustainable manner than has sometimes been the experience with the target-setting implementation of the choice agenda in primary and acute physical care. For example, there has been slow progress in the use of the 'choose and book' software by general practitioners (GPs).

Thus, the government's recommendations regarding the extension of choice in mental healthcare are in principle welcome, but are far from reassuring for mental health service providers if we are expected to follow the acute services/elective care model of delivery. As it stands currently there are several aspects of the choice agenda that, if extended to mental health services without careful consideration, could lead to much confusion and chaos. The challenges of implementation are outlined in Box 2. Already some providers have cast doubt on whether choice of four or five providers is the right way of introducing choice for people with mental health problems (Forrest, 2004).

Box 2 Implementing choice in mental health: the challenges

- A focus different from that of government is required, acknowledging that choice in mental health is not just about location and convenience, but is more meaningfully about life choices and treatment options
- Considerable cultural change is needed to incorporate the ethos of choice systematically in day-to-day practice across all stages and in all disciplines of the multidisciplinary team
- There are occasions when choice cannot be offered and is not possible – how should mental health professionals communicate honestly about this?
- There are occasions when service users and carers might not want or be able to make choices – how should mental health professionals respond?
- How can mental health professionals best support their staff in enabling people to ask for choices?
- Mental health professionals will need to improve the interface between primary and secondary care, and ensure that choice exists at both levels for users
- There are significant staffing issues, for example many more staff will have to be trained and supported to offer psychological therapies
- New commissioning models will be required, including user- or citizen-led options
- Bridging funds may be needed as the transition is made from current service delivery to more individualised and flexible care

The paradox of choice

Aside from the logistical or philosophical concerns raised, mental health professionals have also voiced apprehension about the paradox of choice. This is powerfully highlighted in an editorial by Bate & Robert (2005) in the *BMJ*. They present the argument of the psychologist Barry Schwartz that the amount of choice on offer in life exceeds our ability to effectively exercise that choice, or even to enjoy it. Thus, they write, what mental health professionals need to be mindful of are the challenges that choice will pose for patients who are already psychologically vulnerable, and the risk of 'choice overload', leading to 'bewilderment, high levels of anxiety and stress'.

We also need to ask whether choice in the NHS is real or a political sleight of hand. What are the arguments against choice? There are undoubtedly policies and new services, as we have already mentioned, that are aimed at increasing choice, but are they enough? It could be said that they are the icing on the cake, but that the cake itself is still lacking many vital ingredients. It could be argued that for all its rhetorical commitment to choice, the government has yet to provide policies that will create the fundamental shift in power to the patient rather than the system. The new choices offered in physical healthcare, such as four providers, fast-track day surgery in the independent sector and out-patient clinics held at GP surgeries, are still choices selected for us by commissioners and policy makers. For users of mental health services, choice may be even more limited, when dictated or limited by the Mental Health Act 1983 and compulsion.

The philosophy is still paternalistic. As patients we cannot easily shop around for our own care and clinicians, we cannot choose to go to a GP near where we work, we can only go to services commissioned for us by primary care trusts. The system decides for us whom we see. This is not the case in some European countries and the USA, where patients can directly enlist with a clinician or service of their own choice.

It is beyond the scope of this article to argue the pros and cons of the NHS's mental health commissioning system, but it should be noted that this is a system that contains major impediments

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to choice, such as limited public accountability and involvement, low priority in comparison with commissioning of acute physical healthcare, low resourcing, skills gaps, short-termism in funding of the voluntary sector and a long-time dominance by monolithic NHS providers. The limitations of current commissioning models in relation to choice are discussed in a working paper published by the NHS Confederation (http://www.nhsconfed.org/docs/consultation_21.pdf).

Even attempts to try to shift the power to the citizen are hitting barriers. Direct payments, introduced for people with long-term conditions to purchase their own choice of care, have a patchy uptake. A number of factors are responsible for this slow progress, not least a lack of awareness of the availability of direct payments but, critically, hearsay suggests that financial constraints in the NHS and social care are delaying and limiting access. Although hard evidence cannot be cited, there may be a reluctance to shift decision-making to patients and service users because of a fear that people will want expensive care options or ones that may not be advocated by professionals.

So not only do we have a situation where choice is mediated for us, that choice may also not be real because of resource limitations. For example, demand for psychological therapies far exceeds the sessions commissioned and the capacity of NHS providers to offer them (Layard, 2005). There is a lack of trained staff in many specialties. In the current difficult financial situation of the NHS, services are struggling to maintain core provision, let alone offer choice.

These philosophical and very real financial limitations to choice may form a case for saying there is not and cannot be choice in the NHS. It might be argued that trying to implement choice in this climate is unrealistic and may raise expectations that cannot be met. However, although some of the fundamentals may be missing from policy and choice maybe relative, there are areas where we, as members of the public, patients and professionals, can continue to influence policy and can work to increase choices, as we show throughout this article. As patients we may not yet be able to shop around particularly extensively for our care, but we can influence how we receive that care, the attitudes of staff we encounter, the partnership and dialogue we have in that care. It is often these smaller, everyday choices that ultimately improve experiences and recovery, as countless service user surveys and interviews testify.

Rankin (2005) reports that choice in mental healthcare has associations that differ from those in elective care and that it will operate differently. Service users in mental healthcare have argued for more choice over the treatment options they are offered, as well as support in making choices to live ordinary lives. Discussions with service user groups indicate that people are more concerned about access to services and choice of keyworker than about 'consumer choices' (Barnes *et al*, 1999). This clearly points to the fact that choice in a consumerist sense has a less central role in mental health. Clearly, a different and thoughtful approach to choice in mental health is needed if we are to make the most of the possibilities that it can afford (Box 3). It might be argued that such an approach is likewise needed in physical healthcare, so that patients in these services are also offered a choice of 'how' rather than just 'where and when'.

Box 3 Implementing choice in mental healthcare: the opportunities

- Choice in mental healthcare is not about taking a consumerist approach, but it is about connecting with people and staying connected
- Choice will empower service users and carers to ask for and make more choices
- Choice will change the nature of the relationships between staff, users and carers to one based in dialogue and partnership
- Choice will strengthen the involvement of users and carers in service planning and delivery

The south-east London experience – implementing choice

The different approach required to make choice meaningful in mental health is being explored in south-east London, where a programme to extend choice in mental health services started in 2005. This came about after service users and carers who attended regular mental health events held by the South East London Strategic Health Authority (now subsumed within NHS London) in 2004 highlighted the importance of offering choice. At the time there was no national strategy for introducing the choice agenda in mental health services. Users spoke about the need for better access to therapies, services in convenient places and times, greater involvement in care planning, and support to make life choices (such as access to training, employment and leisure).

The south-east London programme has been developed in partnership with Oxleas NHS Foundation Trust, South London and Maudsley NHS Foundation Trust and Bromley DeVeLoP (an alliance

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Box 4 The four 'choice points'

Each 'choice point' identifies a stage at which service users might most benefit from support and choice

- Making life choices (regarding integration and place in society)
- Access to and engagement with mental health services
- Assessment and planning
- Care pathways

(Care Services Improvement Partnership, 2005*a*)

of community, primary care and mental health organisations). Service users and carers are leading projects as part of the programme and also are key members of the 'support and challenge' group that oversees the work.

The local initiative has built on what already exists as good practice. The key guiding principle has been to be pragmatic, to make explicit and useful links to developments in the National Service Framework for Mental Health (Department of Health, 1999) and to social inclusion initiatives, but at the same time to keep it exciting, creative and continually evolving. This has been achieved by ensuring that the programme was grounded in the ideas and leadership of users, carers and staff.

In 2004 and 2005 events were held to identify core areas for improvement. Over 300 people attended, contributing rich oral and written data. A narrative-based process for capturing the experiences of users and staff has been developed, along with a 'benefits realisation process' to record quantitative evidence of improvement to systems. A 'support and challenge' group, comprising project leads, programme representatives and service users has been created to review evidence of progress.

Eight major innovative projects make up what is one of England's first programmes offering choice in mental healthcare. The programme tests four key areas, called 'choice points' (Box 4), in which users and carers should be offered a range of choices spanning child and adolescent, adult and older adult services. The projects include:

- mentoring for vulnerable children
- skills and support to help people recovering from mental illness to get into training, education and employment
- training for staff to help them support people in making choices
- an interactive information kiosk for children
- increased access to talking therapies
- developing relationships with communities to reduce the stigma of mental illness.

Good progress has been made, and a culture of choice seems to be spreading and embedding across all six south-east London boroughs. There is multidisciplinary leadership in the four key areas (Box 4) and substantial results are being achieved. Highlights of the programme are shown in Box 5.

Box 5 Achievements of the south-east London 'choice in mental health' programme

- Over 100 administrative and nursing staff trained in techniques that enable them to offer service users more choices
- Access to psychological therapies reviewed, recommendations for increased supervision schedules put forward and plans to enable more staff to offer therapies developed
- Materials produced to support service users in returning to employment and for personal development
- Over 30 members of staff and service users trained as 'person-centred planning facilitators'
- A video filmed by service users about having greater choices in care planning featured at the 2005 Disability Film Festival in London
- New staff recruited, including child mentors and community workers
- Plans underway to pilot a CD–ROM-based system for providing general practitioners with up-to-date information about conditions and treatments
- Development of picture-based communication tools for people with learning disabilities that will allow them to express preferences about daily activities
- Widespread introduction of 'dementia care mapping' in partner agencies such as residential and nursing homes, which means staff are seeking to improve the care of older people that the trust is not directly responsible for
- Links made to another south-east London initiative to develop choice in maternity services
- Staff invited by the Institute for Healthcare Improvement to give workshops on the programme's projects at the Institute's Annual European Forum in April 2006 in Prague

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Box 6 Lessons learnt from the south-east London 'choice in mental health' programme

- Mental health must take – and can offer – a unique and novel approach to delivering the choice agenda
- Choice has different associations in mental health – it should mean supporting service users in making choices, however big or small, to live the lives they want
- Choice in mental health has to operate differently from choice in elective healthcare
- Choice in mental health is not merely about location of services
- Choice offers flexibility not only for patients, but also for staff
- Choice will allow innovative ways of working, and staff may benefit from changes in working patterns that result from it
- Improved choice for patients and carers can improve their experience of services
- Bureaucratic systems can block choice: to foster innovation and choice large organisations must be able to move swiftly and be flexible
- Implementing choice will fit well with the National Service Framework for Mental Health
- The choice agenda fits well with, underpins and addresses various other government initiatives, for example Choosing Health, and policies on social exclusion
- Enthusiasm and sustainability of choice can be best brought about by ensuring the involvement and leadership of users, carers and staff

The south-east London programme is one of the first in England to demonstrate that choice can be given in mental health services. It has helped significantly to shape the national Our Choices in Mental Health framework (Care Services Improvement Partnership, 2005*b*). A pan London conference was hosted by the South East London Strategic Health Authority with its partner organisations and the London Development Centre on 28 February 2006 to share the learning from the south-east London experience and encourage further development of choice throughout the capital. For lessons learnt, see Box 6.

The way forward – disseminating choice in mental health

Rankin (2005) predicts that, in the long run, the availability of choice could have a transforming effect on both how mental health services work and how society responds to mental health problems. As we have discussed, there are challenges and dangers, not least that unmediated choice can increase inequity as it can favour patients of more-advantaged groups, which are more vocal and press for their needs (Farringdon-Douglas & Allen, 2005). However, the empowerment ethos at the heart of much mental health policy and practice today offers a way forward.

In the early pilot projects that offered a choice of hospital for surgical treatment, the patients found it very helpful to have the single point of contact and assistance provided by the patient care advisors, who were independent of the service providers (Coulter *et al*, 2005). Bate & Robert (2005) advocate that the NHS should shift the focus to assisted or facilitated choice, and we are of the opinion that this is particularly relevant in mental health. Health and social care workers should be supporting and empowering those who could find the choice agenda complex and complicated, who are at risk of getting lost in a maze of systems.

Methods for disseminating choice in mental healthcare are shown in Box 7. The work in south-east London and other good-practice examples across the country bear witness to the success of this approach (Care Services Improvement Partnership, 2005*c*).

Box 7 Methods of disseminating choice in mental healthcare

- Ensure active user and carer involvement and assessment of the impact of choice
- Take a developmental rather than target-oriented approach
- Focus on a shift in organisational and staff attitudes towards a culture of choice
- Start small and make connections to other key policies and developments
- Adopt a 'choice checklist' or pathway approach, focusing on key areas of innovation
- Apply a benefits realisation approach
- Share opportunities and learning between disciplines and agencies, including those responsible for physical care

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Providers of mental health services should build on the long tradition of user involvement and innovation, harnessing it to drive and translate new choice initiatives and policies. We should be taking a 'whole life approach' and making the daily little choices happen, moving on from a paternalistic and authoritarian approach to one that champions partnership and dialogue. A developmental, continually evolving approach is required, working with users, carers, staff and partner agencies to create and sustain 'bottom-up' interest and continual improvement. The focus should be on changing culture and strengthening leadership, rather than performance management targets and regimes. User and carer views will be the most valuable measure of the impact of the choice agenda.

Conclusions

We hope that this article has contributed analysis, ideas and examples that will open up a wider debate and help to bring about mental health services and experiences for users and carers where:

> 'Choice listens to me, involves me, responds to me, values me, and supports me on my road to recovery. If we are serious about putting service users at the heart of modern mental health services, providing choice is essential' (Laurie Bryant, cited in Care Services Improvement Partnership, 2005*d*: p. 2).

Declaration of interest

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MCQs

1 The 'choice agenda':

a is disempowering for service users and carers
b is not applicable to mental health
c is only relevant for elective procedures in physical healthcare
d cannot be implemented in mental health
e will be a driver for social inclusion in mental health.

2 People with mental health problems:

a do not want to make choices in their treatment
b are unable to make choices
c have complex needs and choice cannot be offered
d should be supported and enabled to ask for choices
e if offered choice will feel marginalised and stigmatised.

3 Choice in mental health:

a is about adopting a consumerist approach
b will empower users and carers
c is disempowering for mental health professionals
d has to be delivered along the same lines as in acute care, without any modifications
e will discourage user and carer involvement.

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4 The south-east London experience of choice in mental healthcare:

a has shown that a 'when and where' approach is best suited to implement choice
b highlights that delivering choice in mental health does not require creative and novel approaches
c has identified life choices as a possible unique area
d identified that it is not possible to implement choice in mental health
e identified that there is no need for a systematic and focused approach.

5 Choice:

a is primarily underpinned by cost benefits to the NHS
b in mental health has to be delivered creatively by adopting novel and unique approaches
c does not allow for innovative ways of working
d in mental health is mainly about the location of services
e does not offer flexibility for patients and carers.

MCQ answers

1	2	3	4	5
a F	a F	a F	a F	a F
b F	b F	b T	b F	b T
c F	c F	c F	c T	c F
d F	d T	d F	d F	d F
e T	e F	e F	e F	e F

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