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Choice: wake up and smell the coffee!

Invited commentary on... Choice in mental health[†]

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Abstract The 'choice agenda' reflects a key element of the modernisation of public services. There are many conceptual and practical difficulties with the implementation of choice within mental health services, but these are not in any way unique to this client group. Professionals will have to adapt to the new world that will encompass a plurality of paradigms of care and service providers.

Few people working within the public services in the UK can be unaware of the 'choice agenda' that dominates contemporary government policy for healthcare, social care and education. As Valsraj & Gardner (2007, this issue) state, the aim is to create a 'patient-led NHS'. This is to involve a paradigm shift that professionals no longer 'do to' but 'work with' patients (also known in mental health services as clients, users and survivors) and their carers.

As Valsraj & Gardner rather neatly put it, the mechanisms that have been put into place in the acute health sector to enhance patient choice rest 'on the twin pillars of competition and plurality of provision'. Thus local health economies are required, under 'choose and book' (Department of Health, 2004), to ensure that at the point of referral for elective care general practitioners offer the patient a range of providers; there have been specific financial incentives for the development of private-sector healthcare provision contracted to undertake NHS work; and, under payment by results,[‡] money for service provision follows the patient. Direct payments and personalised budgets are supposed to produce analogous choice-enhancing changes in the social care system.

Payment by results is yet to be extended into mental healthcare, partly because of the extreme technical difficulty of developing appropriate tariffs that can remunerate providers for the work they actually do. A hip replacement is a hip replacement; the inputs required to undertake the procedure successfully and the care pathway can be generally agreed. The limited number of factors that might influence outcome and costs are relatively easily modelled. Contrast this with the 'package of care' to be offered to someone with schizophrenia, which will or should be highly variable, depending on patient and carer need (and will fluctuate over time).

[†] See pp. 60–67, this issue.
[‡] Discussed on pp. 3–6 and 7–9, this issue. Ed.

The jury is out about the success of these choice-based reforms, although one cannot help but notice that their introduction occurred just before a significant loss of public confidence in the NHS and an unprecedented financial crisis that is affecting mental health trusts, even when they have been historically in financial balance. Paradoxically, investment in healthcare is at an all-time high and, despite public concerns, objective measures of performance show evidence of improvement.

Is mental healthcare different?

Valsraj & Gardner argue that choice in mental healthcare should be seen and understood as in some way different from choice in other spheres of public service. They describe mental health services as 'complex and highly individualised'. This complexity is not, however, unique. Meeting the health and social care needs of a person disabled by rheumatoid arthritis, suffering from a rare tumour or with severe Parkinson's disease is quite complex and requires an individualised approach to the treatment and care plan. Most of the money spent in health and social care goes on the support of elderly people, who tend not to have problems that are neatly compartmentalised.

In fact the ethical basis underlying mental healthcare is no different from that underlying physical

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healthcare. To take an example, consent to mental health treatment is defined in the code of practice to the Mental Health Act 1983 (Department of Health, 1999: 15.13) as:

> 'The voluntary and continuing permission of the patient to receive a particular treatment, based on an adequate knowledge of the purpose, nature, likely effects and risks of that treatment including the likelihood of its success and any alternatives to it'.

Note the word 'alternatives'. This definition is based on the key ethical principle that all health and social care providers should be seeking to maximise the autonomy of their patients.

Mental health professionals have therefore long been required to offer patients (service users, survivors) choices and this requirement has been further underlined in the guidelines published by the National Institute for Health and Clinical Excellence (NICE) (see, for example, the schizophrenia guidelines; NICE, 2002). What is unique in mental healthcare, of course, is the routine use of compulsory treatment and other coercive practices. Given the current 'risk agenda', coercion is set to increase, as we see in the introduction of 'supervised community treatment' (Department of Health, 2006): psychiatric patients are to be encouraged to exercise choice, but with firm limits if they are deemed to present risks.

Myths and truths about choice

In Box 1 of their article, Valsraj & Gardner identify some 'myths' about choice. Some of their 'myths' are actually truths. There is good evidence from the social psychology of choice that too much choice makes us unhappy (Bate & Robert, 2005). This is one of the reasons why, despite massive improvements in the standard of living in the West in the past 50 years, levels of happiness in society have not increased correspondingly (Layard, 2005). It is a matter of record that one element of the choice agenda is funding for independent-sector providers that will offer competition to the hitherto monolithic NHS, and the logic of Valsraj & Gardner's argument suggests that this is no bad thing. (We know that independent-sector providers are very interested in running the psychological treatment centres that were advocated by Layard (2006).) It must be the case that choice has little meaning in a situation where there is no spare capacity. The introduction of payment by results has indeed resulted in destabilisation of mental health services even before it has actually applied to them.

To be fair, some of their 'truths' are true. There is much to applaud in the sentiments expressed in the 'choice checklist' (Care Services Improvement Partnership, 2005), which offers an overview of interesting local projects (including those described by Valsraj & Gardner) and I would urge interested readers to go to the primary source. Rehabilitation practitioners have long been supporting their patients/clients to make life choices in ways that are completely compatible with the newly fashionable recovery paradigm (Roberts & Wolfson, 2004), which conceptually underlies much of the contemporary choice agenda in mental health. Improving choice can have surprising effects: there is, for example, evidence that encouraging people to set out their choices for how they should be supported during relapse episodes results in fewer subsequent compulsory admissions (Henderson *et al*, 2004).

Conclusions

In the current climate it would be impossible to stand against such a self-evident good as choice, but we do need to understand the implications of the choice agenda. It is quite clear that in future health and social care providers will be operating in a marketplace. There will be competition for funds, for patients who will follow the funds and for ideas about how best to tackle the problems that mental health services are there to address. Like their colleagues in the USA, mental health professionals in the UK will need to learn marketing and customer skills if they are to be successful in attracting patients in the brave new world. If they don't attract patients they can't help them.

Declaration of interest

None – other than a slightly old-fashioned fondness for the values of the pre-modernisation NHS.

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