



The Sainsbury Centre
for Mental Health

Mental Health Policy: the challenges facing the new Government

A briefing by The Sainsbury Centre for Mental Health

The Sainsbury Centre for Mental Health is a registered charity, working to improve the quality of life for people with severe mental health problems. It aims to influence national policy and encourage good practice in mental health services, through a coordinated programme of research, training and development. The Centre is affiliated to King's College London (School of Health and Life Sciences).

This briefing describes the issues surrounding current mental health policy and looks at the key challenges that will need to be tackled over the lifetime of the new Government.

It is aimed at all those who have an interest in developing and implementing policies that can deliver excellent mental health services.

Why is mental health important?

- ▶ in Western Countries mental health problems account for a quarter of all time spent living with a disability. Depression, alcohol abuse, manic depressive illness, schizophrenia and obsessive compulsive disorder are five of the ten leading causes of disability;
- ▶ 8–9% of the UK population are treated for depression in any one year;

- ▶ schizophrenia affects 300,000 people in the UK;
- ▶ the total cost of mental health problems to the economy has been estimated at £32bn – the size of the defence budget.

The consequences of not responding to mental health problems appropriately include:

- ▶ if interventions come too late illness can persist longer than necessary, or individuals can lose housing or employment. Considerable effort is then required later in the cycle to try and solve the problems which have arisen;
- ▶ where care is not organised properly, individuals with mental health problems can spend more time in hospital, or be left without support in the community;
- ▶ in extreme cases care breakdowns have led to heavily publicised incidents of homicide or suicide which are damaging for individuals and services;
- ▶ poorly managed mental illness can create long term problems for the families and children of sufferers. The latter can experience educational, social or health problems later in life as a result;
- ▶ the huge economic burden will continue to grow.

I. POLICY

The story so far

Until the 1950s, the main form of provision for mentally ill people was the old Victorian asylum. With the arrival of new medication and the idea that mentally ill people had a right to live in mainstream society, this began to change from the 1960s onwards. The old hospitals began to close and more modern psychiatric units were provided in local general hospitals.

In the initial years of this policy it appears that policy makers under-estimated the level of support which would be required by a relatively small group of severely disabled people who would previously have lived in the old asylums. Insufficient provision was made in the community to support these people. In particular there was an absence of intensive health and social support and supported housing. This contributed to the idea that the policy itself – ‘community care’ – was wrong, whereas the international evidence shows clearly that adequate community care leads to better outcomes for the vast majority of mentally ill people.

In recent decades, mental health services, particularly in inner cities, have been struggling to cope with the combination of demand and negative publicity:

- ▶ psychiatric hospitals are over-utilised and are able to admit only the most serious cases. There are only some 14,000 acute beds for adult psychiatric patients in England. Most are unable to offer much more than medication and containment and there are high rates of readmittance (‘The revolving door’);
- ▶ community teams are hard pressed and lack the numbers and skills of staff to provide intensive support to the most needy individuals. Care is often poorly coordinated;
- ▶ primary care also struggles to identify and treat commoner mental health problems such as depression.

While staff are dedicated and there are islands of good practice and positive developments, as a whole the system of care cannot be said to be functioning adequately.

Current policy

In recent years, mental health policy has been comprehensively overhauled in a major attempt to create a working system of care which can support people with all types and severity of mental health problems. This is a hugely welcome change for the better in the status and priority given to mental health services. The policy has been promulgated in the following publications produced by Government:

- ▶ *Modernising Mental Health Services* which set out the vision of creating safe, sound and supportive mental health services, through a variety of measures including the introduction of more intensive community support services such as ‘assertive outreach teams’ to address the problems of people living in the community with complex needs;

- ▶ *The National Service Framework for Mental Health (NSF)* which sets detailed standards and targets for mental health services;
- ▶ *The NHS Plan* which added to those targets and announced £300 million of new revenue for mental health services. The most substantial investments are in the area of intensive community services where it is planned to provide 50 new early intervention teams to help young people developing severe mental health problems; 335 crisis resolution teams to reduce pressure on hospital beds and 220 assertive outreach teams to support the most disabled people living in the community;
- ▶ *Reforming The Mental Health Act* which described proposals for new mental health legislation which will allow compulsory care in a community setting as well as hospital.

The essence of the policy is to put in place a network of services which can:

- ▶ manage patients safely in the community, minimising risks to their own and other’s safety;
- ▶ provide comprehensive support which can support social inclusion and assist recovery;
- ▶ use the international evidence base as to what works best to ensure that the £3.5bn spent each year on mental health services is used efficiently.

What are the key issues?

Current Government policy is welcome on a number of fronts:

- ▶ it is comprehensive and covers all the main service elements necessary to develop modern mental health services;
- ▶ it gives mental health a higher priority than ever before;
- ▶ it promises real growth in spending.

However, as with many other public services, there are deep structural and human problems which have to be tackled if modernisation is to be delivered. There is currently a huge gap between this comprehensive and ambitious policy programme and the situation of local services, which are struggling to deliver even the most basic care. Many staff are dedicated but there is a lack of the right skills and leadership to deliver change on the massive scale required. There are therefore six fundamental challenges to be addressed over the next five years:

- ▶ tackling discrimination and stigma;
- ▶ achieving change management to implement a comprehensive system of care;
- ▶ getting the right organisational models;
- ▶ getting the right skills and numbers of staff;
- ▶ developing adequate local leadership;
- ▶ developing the infrastructure to support change.

In addition, there is currently an over-emphasis on achieving safety to the detriment of some of the principles set out above. Services are fundamentally about supporting people to recover from mental illness, not about social control, and the assessment of individual need must be the primary driver for all care decisions. Like other health services, mental health services aim to cure or ameliorate ill health.

2. THE VISION

What then is the SCMH vision for mental health services?

It is suggested that the two core values for mental health services are **equality** and **fairness**:

- ▶ **Equality** for people who experience mental health problems requires
 - positive action to enable people to function and to take up the same opportunities as other citizens, for example, opportunities for education or employment, and to gain the same level of access to services. The level of support required should be matched to the level of need;
 - an absence of discrimination which denies people opportunities due to structural discrimination, stigma or stereotyping;
- ▶ **Fairness** means that people with the greatest levels of need receive the highest priority in terms of the access to and quantity of services which they receive. It recognises that resources are finite, but requires that the allocation of services to individuals and communities is fair and is based on need.

In order to make these values a reality it is necessary to build services which are:

- ▶ **Of high quality.** This means that both hospital and community services must be structured so that they help patients to recover and to function better, and that staff must have the right skills and knowledge to deliver therapeutic care. Many services fail currently to reach even basic quality standards;
- ▶ **Comprehensive** so that they embrace all the key elements of care. Severely mentally ill people, in particular, need a range of services in addition to health care, crucially also including:
 - accommodation
 - adequate income from benefits or preferably paid employment
 - meaningful daytime activity
 - social care and support with the tasks of daily living.

These services inevitably have to be delivered by a variety of different agencies working together, but care needs to be built around multi-disciplinary community mental health teams covering localities. With some groups of people care will be focused on one of the new

types of intensive community services (e.g. assertive outreach teams). The SCMH is not aware of any local service that currently delivers all the required elements of care, in sufficient quantities;

- ▶ **Integrated** so that care is coordinated and so that individuals find themselves in the right part of the system at the right time. There is currently a large amount of evidence from inquiries and user experience that care is not properly coordinated. The Government's White Paper *The New NHS* helpfully placed the concept of integrated care at the centre of reform. It is a pity that the centrality of this concept seems to have been lost in more recent policy. Services need to be designed around patients so that
 - different agencies such as health, social care and housing work together;
 - different parts of NHS services such as primary care, hospitals, community teams and specialist teams are coordinated and the patient ends up in the right part of the system at the right time.

This cannot be achieved unless clear care pathways are defined for different disorders and levels of need, and unless one worker has lead responsibility for care coordination and planning for a patient and he or she is able to work across agencies;

- ▶ **Focused** so that the response from services matches need. At present some services, e.g. acute inpatient care, are poorly focused and require fundamental reform. In others, e.g. primary care, best care matches international standards but the response is patchy and inconsistent. It is also not clear that users with the same level of need receive the same level of appropriate service across the country. Some users with less severe problems are 'held onto' by services far too long, when other people with more complex needs cannot access the right care;
- ▶ **Evidence based** so that services are developed and delivered according to the best available evidence including research of different types, and user, community and professional views. In common with much of health care, only a small proportion of mental health care is currently based on the available evidence.

3. THE SIX KEY ISSUES

Discrimination and stigma

This is one of the most difficult issues to address through public agencies because they are service oriented, and only have limited levers to change public perception of mental illness. Nonetheless, it is fundamentally important as exclusion and stigma can often cause patients more problems than the illness itself and because they limit the effectiveness of services. Discrimination against people with mental health problems affects their recovery but also limits the effectiveness of services. Structural discrimination needs to be addressed by government and public agencies and effective programmes to combat stigma developed. This issue will have to be given a much higher priority by all the agencies concerned. The current £1m PR campaign by Government is merely a first step to solving such a deep rooted and pervasive problem.

More effective steps should be looked at to tackle discrimination and stigma:

- ▶ **Getting a job is key to most service users' sense of worth and to social inclusion. The NHS and local authorities should be set targets for the employment of mental health service users, starting with mental health services themselves;**
- ▶ **Current anti-stigma initiatives need to be coordinated and focused, with a single agency recognised as leading the work and holding the budget;**
- ▶ **All forms of systematic discrimination against people with, or who have suffered from, mental illness should be removed from current legislation, and the benefits trap for people with long term mental illness must be addressed;**
- ▶ **Government should honour its commitment to carry out a national survey of user satisfaction with mental health services, and the results should be widely disseminated.**

Change management

There are profound difficulties in moving from current services to a comprehensive system of care:

- ▶ acute psychiatric care currently offers an unacceptable environment and there is no evidence that it is therapeutic. Yet hospitals cannot be improved without alternatives to relieve the pressure;
- ▶ but putting the new intensive community services in place absorbs much management capacity and sucks good quality staff out of hospitals;
- ▶ many professionals are not yet ready to think in terms of a comprehensive modern service – they are still focused on the hospital/outpatient clinic type of model.

There is no chance of achieving comprehensive, modern services without the right financial and human resources, and specifically without the support of professionals:

- ▶ **we must create a cadre of professionals, and especially psychiatrists, who are trained for and committed to clinical management, so that they can lead change. This means fundamental change to professional education and the development of formal career pathways in clinical management to which a substantial group of professionals will commit themselves. This agenda has to be led by Government if there is to be any chance of success.**

Organisation

The current structures for the commissioning and provision of mental health services are complicated and rapidly evolving. Structural change within the NHS and social services forms an important backdrop to the implementation of mental health service modernisation and could work for or against integrated care. At present the direction of change for service structures is broadly as follows:

(a) Commissioning

Strategic planning and commissioning is done by health authorities, which will get larger and will be less involved in commissioning high volume mental health services. These will increasingly be commissioned by primary care groups and primary care trusts (PCTs). Social services departments will increasingly commission social care for mentally ill people through joint commissioning with the NHS or through care trusts.

The key question is the extent to which we need specialist commissioning of mental health services. Mental health services are highly complex and the pool of experienced commissioners in particular is very small. This has been inadequate to provide health authorities with sufficient mental health commissioning expertise so it is hardly likely to be adequate if divided amongst PCTs. **This suggests that the following sorts of models might make the best use of expertise:**

- ▶ **joint commissioning across health and social care by a joint commissioning board drawing on expert mental health networks which consist of key individuals from across the local health and social care economy;**
- ▶ **pooling of commissioning expertise by PCGs and PCTs, or the designation of one focal point PCT for mental health, which aims to develop specific expertise in mental health, within each health authority area.**

(b) Provision

Specialist mental health services are increasingly being provided by large specialist mental health trusts. Care trusts can be extensions of PCTs or specialist mental health trusts into the social care arena and these will also multiply. Some PCTs are taking on provision of certain mental health services – usually community services, but in a few cases also inpatient services. The boundaries between specialist mental health trusts and PCTs are likely to be fluid.

There is currently no single direction for structural change in mental health. There are however, two broad emerging models which will be subject to local variation:

- (a) Most specialist mental health services will be provided from specialist mental health trusts and commissioned by PCTs which will provide the primary care;
- (b) Some specialist mental health services will be provided by PCTs with only highly specialised services provided by a trust.

Model (a) has the advantages of creating a critical mass of expertise and delivering an exclusive focus on the implementation of mental health policy. However, it may be perceived as large and remote, and may lock resources into unsuitable units and structures. Model (b) has the advantage of linking primary and secondary care and encouraging locality focused provision, but has strong potential disadvantages such as possible lack of expertise and a tendency to skew provision towards common mental disorders, disadvantaging clients with severe mental health problems.

Either of these models can involve care trusts which would helpfully integrate health and social care within the specialist mental health trust or PCT type structure. Care trusts are a welcome development for mental health and this approach must be evaluated and the lessons learned.

Workforce

Mental health services rely entirely on the skills, knowledge and commitment of staff. Current services benefit from significant numbers of highly skilled and committed staff. However, there is strong evidence of shortages of staff in all the main professions – psychiatry, nursing, clinical psychology, social work and occupational therapy. For example, in psychiatry about one in eight consultant posts are unfilled at any one time, and in nursing there is heavy reliance on agency nurses to cover vacancies. Many existing staff seem to be demoralised, under pressure or exhausted by constant change. This issue would be hard enough to tackle even in a time of stability and consolidation. However, the NSF and NHS Plan make massive demands:

- ▶ it is estimated that the commitments in the NSF and NHS Plan will require some 8,000 new staff – a 12% increase on the current workforce;
- ▶ new ways of working will require flexibility, commitment and retraining, as would the type of vision for mental health services set out above;
- ▶ the changes envisaged in current plans will require a high level of motivation, especially from clinical leaders and managers.

It is hard to see how many providers, especially inner city Trusts, will even be able to reach their current required staffing establishment within the current labour market, let alone recruit more staff. The problem is particularly acute in areas which are regarded as undesirable for families but which have high property prices such as London.

Large numbers of talented and committed people from all backgrounds need to be attracted to mental health. In order to do this a whole range of measures will need to be explored such as:

- ▶ family friendly policies;
- ▶ using the mature, younger and non-qualified workforce;
- ▶ changing skill mix and working practices and developing training plans to match;
- ▶ pay flexibilities;
- ▶ a range of other measures to make jobs in the sector more attractive, including more autonomous practice and programmes to address the mental and physical health of the workforce, as recommended in the SCM report *Finding and Keeping*.

The problem is that while these HR good practice solutions to recruitment and retention problems are widely known they are not currently implemented in mental health, and given the massive gap between supply and demand in some areas, they may not in themselves be sufficient. In some areas it may have to be acknowledged that sufficient quality professional staff will simply not be available. Careful time-tabling of some of NHS Plan's aspirations may be required. National work so far has looked at developing the workforce largely by increasing numbers and skills within current staffing models.

However, it is clear that the shortfall of numbers and skills is so great that we will also have to look at more radical options such as changing skill mix, disinvestment in ineffective services and smarter working. The latter could include better use of IM&T and streamlining working practices. SCM has initiated a work programme to look at these more radical options.

Leadership

Current mental health policy is currently highly prescriptive and is strongly centrally led. While this approach has its merits it allows little scope for the emergence of precisely the type of local leadership which Government says it is seeking, and which is required to provide change management. Steps need to be taken to empower local managers and in particular clinical leaders, to find local solutions that work and adapt central models to local needs, while sticking to broad principles.

Measures which could support local leadership include:

- ▶ **devolution of decision making and budgets to the lowest possible level, including giving team leaders in hospitals and communities the team budget and individual clinicians care budgets;**
- ▶ **rationalising centrally led performance management and planning systems to minimise the requirements on local staff and to focus on outcomes;**
- ▶ **giving clear messages centrally about what can be left to local decision.**

Infrastructure

Significant new resources are available to recruit new staff, should they be available. However, the resource to improve the basic infrastructure for mental health services is wholly inadequate. A major gap is the lack of capital to redevelop the currently totally inadequate facilities for acute psychiatric care. Given that there are few psychiatric units which are fit for purpose, most will require either a complete rebuild or major redevelopment to deliver a suitable service. This could cost hundreds of millions nationally, although there is significant scope for land sales and rationalisation in many health economies. This area requires detailed analysis.

Similarly, significant resource is required for IM&T (information management and technology) which is very poorly developed in this sector, but has great potential to support good clinical care in the ways described in the Government's White Paper *Information for Health*, including the development and use of clear care pathways.

- ▶ **Each health authority should produce a costed strategy for improving the mental health estate and delivering single electronic mental health records which should then be prioritised for central capital funding over a realistic timescale (i.e. 5–7 years).**

Next steps

SCMH will be carrying out some detailed analytic work on these issues over the next 6 months with a view to generating solutions to the current gap between policy and realistic plans for implementation:

- ▶ it is considering how best to develop a user empowerment programme aimed at helping to tackle discrimination;
- ▶ it will work with the other key national agencies to develop leadership programmes to help develop local leaders, particularly clinical leaders, who can initiate change;
- ▶ it will shortly produce an analytic paper on new structural models for mental health care provision and commissioning;
- ▶ it is undertaking a programme of work to look at radical solutions to workforce problems in mental health.

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