Mental health services in the NHS: using reform incentives

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Executive Summary

- Mental health is a central priority of modern health care. In terms of disability adjusted life years, it imposes the second highest burden of disease in Europe (only just behind cardiovascular disease).

- But services are narrow and – for the great majority of sufferers – impose unacceptable waits for treatment during which mental illness can become entrenched.

- Several organisations and commentators have concluded that the vast majority of sufferers, suffering from common yet disabling disorders such as depression and anxiety, may never see a mental health specialist. For example:
  - The Healthcare Commission (2005) found that only half of people with depression were receiving treatment and that people are waiting “a long time” for appointments with psychiatrists and other mental health professionals.
  - The OECD (2005) reported that patients have to wait “six to nine months” to access psychotherapy while conditions become more entrenched.

- Spending has increased since 1999-00 with the aim of developing a more community focused service. But the funding has gone in quite a different direction:
  - Between 1999-00 and 2003-04 spending on inpatient, outpatient and day patients services within the Mental Health Services Programme Budget increased from £3 billion to £4.1 billion (real terms).
  - In contrast spending on community mental health nursing and community mental illness nursing rose from £1.3 billion to £1.7 billion.
  - Numbers of short hospital stays have decreased while numbers of long stays have grown greatly. The number of patients whose duration of stay is over a year has increased by 192 per cent between 1999-00 and 2003-04.
  - From 1999-00 to 2003-04 spending on inpatient care at constant prices rose by £600 million (+27 per cent). The number of admissions fell from 200,900 to 171,650 (-15 per cent). Thus real terms spending per admission rose from £11,200 to £16,600 – a rise of 48 per cent – against a background of increasing concern about the quality of inpatient care.

- The whole programme has developed as a custodial model with high levels of compulsory treatment rather than a health programme which clients engage with voluntarily in order to achieve benefits. Funds are concentrated on the 0.5-2.0 per cent of the population who suffer from psychotic illness, yet the vast majority, suffering from common yet
disabling disorders such as depression and anxiety, may never see a mental health specialist.

- The lack of investment in community care is compounded by poor use of modern effective drugs. We present new analysis of use of atypicals in different SHAs and PCTs. Prescribing of atypicals as a proportion of total anti-psychotics varies between 55-60 per cent in some SHAs to below 40 per cent in others.

- In the absence of community care, the service operates with very high levels of compulsory treatment. The number of detentions under the Mental Health Act rose from 24,811 in 1987-88 to 46,003 in 1998-99. In the most recent year 2003-04 there were 43,847 detentions. These figures suggest that of adults over 65 admitted to hospitals, 40-50 per cent are being treated compulsorily with the proportion nearing 70 per cent for patients from ethnic minorities.

- It is apparent that mental health services are excluded from the mainstream of NHS policy and – most importantly – from the benefits associated with the new reform programmes:
  - There were no targets for waiting times in mental health services which are much longer than acute services. Even now the 18 week target does not apply to non-consultant led services which are particularly important in mental health services.
  - Services must now compete for additional funding without help from compulsory targets. Many are losing funds to cover deficits in acute trusts.
  - Despite their use in acute services, choice and pluralism are a very low priority for mental health services. There is no constructive long term partnership with the private and voluntary sector. The current relationship is based on spot purchasing; a model which is regarded as delivering high cost and poor communication.
  - The postponement of the introduction of payment by results to mental health services is a major blow. Payment by results and the national tariff are major drivers for developing pluralism.

- The new care model with its emphasis on early intervention, community support, reduced admissions and much more help to return to employment is clear enough. The key issue now is to make it happen in this very difficult funding environment.

- Here the reform incentives could be crucial. Those with a strong preference for remaining with the monopoly model see them as highly threatening. But choice, direct payment and pluralism offer the only realistic way of making progress towards the new kind of care which is there for the making. We would urge the following steps:
- **Develop a mixed economy of care in cognitive behavioural therapy (CBT) and other local preventive services.** It was notable that the two pilot schemes in wider CBT in Doncaster and Newham were not put out to tender even though there would have been considerable private and voluntary interest in providing for them.

- **Introduce direct payments for people needing therapy in the community.** There are many professionals at present who wish to do this work but cannot do it because of rationed funding in the NHS.

- **Make much more use of direct payment for patients who are reaching the discharge/rehabilitation stage.** Direct payment can be used for support in moving to accommodation, for employment skills training and/or for activity which contributes to recovery.

- **Develop a strategic partnership with the private and voluntary sector to accelerate investment.** Such a partnership could bring about a substantial change in three years, especially as the change could unlock some of the large property assets within the existing hospital system.

- **Introduce a much more active commissioner/provider relationship.** To some extent mental health services have been the area which the internal market forgot. Now joint commissioning with social services supplies a chance for a more effective use of the new incentives. The introduction of payment by results is essential.

- It is now widely appreciated that mental illness is not simply a medical problem – it often raises a moral challenge of helping individuals to regain independence. The compulsion of monopoly is the very opposite of this independence. Choice and pluralism will enable a successful pursuit of this goal of independence.
1. Introduction

Our aim in this report is to review the strategic outlook for improving services for people with severe mental illness and to make some positive proposals for ensuring that patients can benefit from the new agenda of choice and quality.

We write with a sense of great urgency. The Five Year Review of the National Service Framework (NSF) conveys a somewhat favourable impression which verges on wishful thinking. The difficult question of whether incremental change – a mixture of new teams and a propping up of the old acute services – can lead to the radical change in the quality and range of services which are required is completely ignored.

There has been some progress in improving services which is covered in the Five Year Review, in particular the starting of new teams and high levels of patient satisfaction. However progress has been slow. A Healthcare Commission Survey showed that 77 per cent of patients in mental health services were satisfied with the service they received.¹ But such response, though welcome and a tribute to the dedication of staff, must be treated with caution if the expectations of patients are very low.

There is a much clearer focus on social inclusion as the most important aim for patients. Treatment outcomes may have improved through the availability of new drugs and better support.

But will these produce real gains for patients in terms of life chances? Often in the past patients have become career patients cut off from society with few relationships and little access to opportunities in housing and employment. It is the realistic potential of moving towards a real improvement in choices for patients which adds some urgency to the search for a different model. The opportunity is available:

- There is a new generation of professionals – often working as community staff or ward managers – who are moving away from the purely medical model and have the confidence and expertise to help patients in more short-term intensive treatment. There is in fact a new generation of young leaders who are capable of managing new kinds of projects.

- There has been an increase in the involvement of user and carer groups in managing services. There is a much more active constituency for better services than was the case a few years ago.

- There has been an increase in the potential contribution of private and voluntary providers. These providers are now offering more services and there is the potential for moving beyond spot contracts for emergencies towards a more strategic relationship with a greater range of providers.

- The closer partnership with social services creates opportunities for greater use of direct payments and of the mixed economy of care.

¹ Survey of users of services, Healthcare Commission, September 2006
Recently there have been some very positive reports and campaigns that have emphasized the importance of improving services in mental illness. Lord Layard’s report for the Cabinet Office in 2004 documented the gains from the expansion of psychological therapies including Cognitive Behavioural Therapy (CBT). In 2005, Rethink and the IPPR produced an excellent report titled *Mental health in the mainstream*. The One in One Hundred campaign launched in July this year has provided fresh impetus for a re-appraisal in showing very clearly the continuing impact of schizophrenia on patients, carers and society.\(^2\) The recent review – *Ten High Impact Changes for Mental Health Services* by the National Institute of Mental Health – has set out very clearly how services need to be improved.

It is now widely appreciated that mental illness is not simply a medical problem – it often raises a moral challenge of helping individuals to make choices and to live independently. Mental illness often means that people cannot function as independent human beings and recovery must mean that they regain the ability to live independently and to make choices. This is why rehabilitation through access to employment and housing opportunity is so important. In pursuit of this goal of independence it is surely logical that patients would be offered an increasing amount of choice as their recovery continues. The compulsion of monopoly is the very opposite of the independence and choice which is central to recovery. Where improvements have occurred they have been painfully slow.

We need to take a realistic look at whether the services as currently modelled can really deliver security and choice. There seems to be an increasing paradox – that choice and pluralism are required for acute services but are a very low priority for mental health services. There has been a failure to define a constructive long term partnership with the private and voluntary sector. The current relationship is based on spot purchasing; a model which is regarded as delivering high cost and poor communication.

The continuing model of state provided monopoly is very different from the mixed economy of care in social services and has probably made joint working more difficult. There has been a postponement of the introduction of payment by results to mental health services – a major blow as reform needs to be sped up not slowed down. By postponing payment by results trusts who worked hard to prepare for its introduction have been left dismayed and trusts who didn’t have essentially been rewarded for their failure. Payment-by results and the national tariff is also a major driver for developing pluralism in mental health provision.

The ingrained mindset of commissioners at all levels below the Department of Health seems to be that the NHS “family” provides the totality of (health) care. The third sector, whether profit or the so called not for profit, is seen as peripheral to mainstream thinking. To some extent, this is driven by the Department of Health since Key Performance Indicators either tend not to

\(^2\) [www.oneinonehundred.co.uk](http://www.oneinonehundred.co.uk)
recognise such expenditure with non-NHS providers or at worst, negates against it.

There were no targets for waiting times in mental health services which are much longer than acute services. Even now the 18 week target does not apply to non-consultant led services which are particularly important in mental health services. Many services such as CBT are unavailable because waiting lists are so long that they have been closed.

There seems to be a compulsion to stay with the present model rather than to use the reforms fully. In many ways a cultural gap is opening between acute services based on choice and pluralism and mental health services which are still a monopoly.

In this paper we set out the case for using the new reform incentives much more actively: far from being a threat to better mental health services they offer hope of more rapid progress and a more creative adjustment to an era of likely low growth in spending.

Some argue for a choice of treatment rather than a choice of provider. The reality is that state monopoly services move so slowly that the only way to ensure a choice of treatment, as well as reasonable access times and good quality environments is to create a choice of providers.

We need to look for new and innovative ways to get more rapid progress in terms of improved service particularly when there are many signs that mental health services will lose priority for funding compared to acute services. Previous reports have given us a list of many fine aspirations – but how will we actually make them a reality? It is significant that after seven years of the NSF the Government has announced a new special allocation of £130 million to remedy the most basic deficiencies in accommodation for people with serious mental illness. But there is little evidence that the funding for this is evident locally. A recent report from the Sainsbury Centre for Mental Health has noted that mental health trusts tend to faces lower funding increases than the NHS as a whole and face financial difficulties due to deficits in other parts of the service.

There is of course considerable capital and new buildings within the independent sector that could be used immediately to treat NHS patients therefore negating the need to spend what is unnecessary public sector capital.

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3 £130 million investment for mental health, Department of Health press release, 20 October 2005.
4 Under Pressure: the finances of mental health trusts, Sainsbury Centre for Mental Health, July 2006.
2. Access to mental health treatment

Access to specialist mental health services and psychological treatment

The burden of mental illness is great. The NHS Improvement Plan includes estimates of the disease burdens, which show that mental ill health is second only to cardiovascular disease in disability adjusted life years (see Table 1).

<table>
<thead>
<tr>
<th>Cause</th>
<th>Disability adjusted life years</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular Disease</td>
<td>33,381</td>
<td>21.8</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>31,080</td>
<td>20.3</td>
</tr>
<tr>
<td>Injuries</td>
<td>22,707</td>
<td>14.8</td>
</tr>
<tr>
<td>Cancers</td>
<td>17,642</td>
<td>11.5</td>
</tr>
<tr>
<td>Digestive Diseases</td>
<td>7,087</td>
<td>4.6</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>6,823</td>
<td>4.4</td>
</tr>
<tr>
<td>Respiratory Diseases</td>
<td>6,416</td>
<td>4.2</td>
</tr>
<tr>
<td>Musculoskeletal Diseases</td>
<td>5,304</td>
<td>3.5</td>
</tr>
<tr>
<td>Sensory Organ Disorders</td>
<td>4,150</td>
<td>2.7</td>
</tr>
<tr>
<td>Respiratory Infections</td>
<td>3,891</td>
<td>2.5</td>
</tr>
<tr>
<td>All Other Causes</td>
<td>14,631</td>
<td>9.5</td>
</tr>
<tr>
<td>Total</td>
<td>153,111</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: The NHS Improvement Plan, Department of Health

Spending on mental health services has risen within the UK over the past five years. However, the majority of resources are being concentrated on the minority of patients who are regarded as high risk in terms of violence. Many groups of patients who are in urgent need of help and where the social returns would have been positive have great problems of access. The Review completely fails to provide evidence on the quality of service for people where illness is not a major risk to others. The whole programme has developed as a custodial model with high levels of compulsory treatment rather than a health programme which clients engage with voluntarily in order to achieve benefits. There is currently a concentration of funds on the 0.5-2 per cent of the population who suffer from psychotic illness, yet the vast majority, suffering from common yet disabling disorders such as depression and anxiety, may never see a mental health specialist.

Waiting times for therapy services in the community are now far longer than for most treatments for physical illness. The Five Year Review reported some growth in the numbers of psychologists and therapists but there seems little chance that such waiting times will reduce at any time in the future. Some of the worst experiences of waiting – for example in child psychology services where the waiting was so long that the client was no longer a child – may
have been reduced: but waiting times are such that for many clients the services may become completely irrelevant.

Targets for reducing waiting times have not been applied to mental health services. This may have meant less attention and a lower priority from funding organisations. It has certainly reduced the sense of urgency about reducing waiting times especially for psychological therapies.

The Department of Health project for Graduate Mental Health Workers was an imaginative initiative that where implemented and understood could have had a huge impact on primary mental health with a subsequent impact across the whole systems, for example through faster return to work following depression. Unfortunately, the Graduate Mental Health Workers were rolled out too late in the process without sufficient understanding by the majority of commissioners and providers as to their role.

Several organisations have previously noted the poor performance of mental health services in England despite their high and growing importance. In particular, these reports highlight that many patients are not being seen by specialist mental health services, and where referrals are taking place, waiting times are long.

**Healthcare Commission**

In its report, *State of Healthcare 2005*, the Healthcare Commission said that mental health services “fall short of national standards” despite the fact that “one in six adults requires some sort of mental health support”. It found serious problems with:

- **Access.** “Only two thirds of community-based crisis resolution teams operate 24 hours a day and fewer than half of people who receive mental health services reported that they had access to crisis care.” It also found that “only half of people with depression were receiving treatment, only 8 per cent had seen a psychiatrist and only 3 per cent had seen a psychologist”. This was “despite strong evidence that both drugs and psychological treatments could provide real benefits to people with mental health problems”.

- **Waits.** It said that “information on waiting times for mental health care is not collected nationally” but that there was evidence to support the claim that “people are waiting a long time for appointments with psychiatrists and other mental health professionals”.

- **Variations in care.** It also reported serious problems with variations in care across the country noting that the National Service Framework for Mental Health found significant differences in PCT spending on mental health care, including a widening gap between the North and the South.

- **Inequity.** The Commission noted that “some disadvantaged groups are more likely than others to fail to receive services”.
In September this year the Commission published its first national review of adult community health services. Assessing the 174 Local Implementation Teams (LITs) – who are responsible for ensuring community services – it found that only just over half of were rated as “excellent” or “good”. Mirroring its previous report it found poor access to out-of-hours crisis care and accommodation. Only 50 per cent of people had access to talking therapies and in 20 per cent of LIT areas this figure was significantly lower.\(^5\)

**King’s Fund**

In their *Independent Audit of the NHS under Labour (1997-2005)*, the King’s Fund drew on previous research and stated that “there has been no shift in performance, despite the extra resources” in mental health services.\(^6\) It noted that there had been little improvement in star ratings for mental health trusts and that one summary of inspection reports found that the majority of trusts “face significant challenges” with a “high use of agency or locum (that is temporary) staff, long waits for children and teenagers to be seen by a specialist, long waits for psychological therapies, and problems in getting patients in and out of acute inpatient care”.

**OECD**

In its latest *Economic Survey of the United Kingdom*, the OECD noted poor performance in mental health services and the effect this had on people suffering from mental illness:

“Today, patients still have to wait for six to nine months to access psychotherapy while conditions often become more entrenched .... Using a combination of medication and cognitive behavioural therapy, most people suffering from depression can be helped to a point where they can work most of the time, and having something meaningful to do is in itself a help.

“Yet, in Britain only one in five persons suffering from severe depression gets the chance to see a psychiatrist. For some, this is because they themselves do not seek or wish treatment, but in most cases it is because of capacity shortages so that general practitioners are left with the responsibility of treating the person. Patients have to wait for six to nine months to access psychotherapy while conditions often become more entrenched.”\(^7\)

**Postcode rationing of new therapies**

There is a backlog of unfinished business in ensuring that patients can get access to new therapies. There has been much discussion about the role of different drug therapies but now NICE has supplied definitive guidance.

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\(^7\) *Economic Survey of the United Kingdom*, OECD, 2005.
Here we present the facts about the level of compliance with NICE recommendations.

The Technology Appraisal by NICE estimated that in England and Wales there are 210,000 individuals who are potentially eligible for treatment with atypical anti-psychotics. Of these 30 per cent were estimated to be in the treatment resistant group who would not use the first line therapies. NICE estimated that some 60 per cent of remaining patients should move to the newer therapies, which would involve use by some 80,000 patients.

Our study follows a recent review of postcode rationing in the use of new anti-cancer drugs. Some of these recommendations began implementation well before the recommendations on atypicals. The report by the National Cancer Director showed considerable concern about the differences in access to new therapies. Our study shows that there can be similar concerns in other areas. Indeed the differing rates of prescribing in mental health seem somewhat larger than in the case of cancer therapies. During a period of increased concern about the implementation of NICE recommendations this is the only set of NICE recommendations that affects patients with severe mental illness.

We have made a detailed examination of each individual Primary Care Trust in all of the Strategic Health Authorities. PCTs are now assessed by the level of implementation of this and other NICE guidelines. Performance levels are shown in Table 2 below with Grade 5 representing the highest level of implementation.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Percentage Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Under 35 per cent</td>
</tr>
<tr>
<td>2</td>
<td>35.9 per cent to 43.5 per cent</td>
</tr>
<tr>
<td>3</td>
<td>43.5 per cent to 54.6 per cent</td>
</tr>
<tr>
<td>4</td>
<td>54.6 per cent to 60.0 per cent</td>
</tr>
<tr>
<td>5</td>
<td>More than 60 per cent</td>
</tr>
</tbody>
</table>

We summarise data on the current percentage of atypical prescribing as a proportion of total anti-psychotics – prescribed in each individual PCT in England – and prescribing levels within SHA areas.

There are nine SHAs where on average prescribing levels are in the 54.6-60.3 per cent range, thirteen in the 3rd grading between 43.5 and 54.6 per cent and four in grade 2 with atypical prescribing between 39.5 and 43.5 per cent and one with prescribing well below 33.9 per cent (data was available from 27 out of 28 Strategic Health Authorities). The range in 2004-5 was from South West London with 60.7 per cent to Trent with 33.9 per cent.

We can identify the 30 PCTs, which were top and bottom performers. Of the last 20, 14 are in the East Midlands and East Anglia. There is only one of the

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8 Review of variations in the usage of cancer drugs approved by NICE, National Cancer Director, 2004.
bottom 20 PCTs (East Surrey) in the South East. In contrast 16 of the top performing PCTs are in the South East or the London area and only four – Airedale, Coventry, North Tyneside, Newcastle and Central Cheshire – are in the North or the Midlands.

These results are even more striking given that atypicals are hardly ‘new’ and they are not really that expensive in the context of other modern medication as well as having a significant positive effect in terms of value for money across a whole systems approach.

**Greater community based care**

The lag in use of new therapies is one indication of the challenges facing mental health services. But there are other signs that mental health services are having great problems in moving towards a more personalised community based model of care. Any move towards higher spending on community teams is taking place against a background of additional spending on hospitals.

| Table 3: The Mental Health Services' Programme Budget (£ million 2003-04 prices) |
|---------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|
|                                 | Inpatients      | Outpatients     | Day patients    | Community mental health nursing | Community mental illness nursing |
| 1999-00                         | 2,257           | 408             | 362             | 534             | 740             |
| 2000-01                         | 2,513           | 448             | 369             | 561             | 845             |
| 2001-02                         | 2,601           | 521             | 339             | 515             | 862             |
| 2002-03                         | 2,767           | 674             | 354             | 541             | 937             |
| 2003-04                         | 2,857           | 882             | 316             | 640             | 1,033           |
| Increase                       | +600            | +474            | -46             | +106            | +293            |
| Percentage increase            | +27             | +116            | -13             | +20             | +40             |

*Source: Public expenditure on Health and Personal Social Services, Department of Health Memorandum to the House Commons Health Select Committee, 2005*

Thus from 1999-00 to 2003-04 spending on inpatient care rose by £600 million (27 per cent) even though the number of admissions fell and serious concerns remained about quality.

It is worth noting that with the possible introduction of the Mental Health Bill (having previously been shelved in March 2006, Patricia Hewitt has said a new streamlined version will “be introduced as soon as parliamentary time allows”9) there could be an increase in the use of non-residential orders which will see compulsory treatment being carried out forcibly in the community. The King’s Fund has stated “there will probably be a year-on-year increase in the number of people on orders as they become part of the mental health

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9 Oral answer to a written parliamentary question, 18 July 2006 col 150.
system and their effectiveness for some patients is demonstrated”. While this raises concerns about the liberty of patients who are given compulsory treatment, it indicates that there will be further movement towards community based rather than acute based care.

Data for inpatient length of stay shows that much of the increased spending on hospital care has been used to fund patients staying over a year (see Table 4 below). There has been some success in reducing short admissions under a year but this has been in line with the general reduction in all stays between 1999-00 and 2003-04.

<table>
<thead>
<tr>
<th>Duration</th>
<th>1999-2000</th>
<th>2003-04</th>
<th>Number increase or decrease</th>
<th>Percentage change</th>
</tr>
</thead>
<tbody>
<tr>
<td>All durations</td>
<td>200,900</td>
<td>171,650</td>
<td>-29,250</td>
<td>-15</td>
</tr>
<tr>
<td>Under 1 week</td>
<td>45,640</td>
<td>38,260</td>
<td>-7,380</td>
<td>-16</td>
</tr>
<tr>
<td>1 week – 1 month</td>
<td>82,230</td>
<td>65,410</td>
<td>-16,820</td>
<td>-20</td>
</tr>
<tr>
<td>1 month – 3 months</td>
<td>50,500</td>
<td>43,750</td>
<td>-6,750</td>
<td>-13</td>
</tr>
<tr>
<td>3 months – 1 year</td>
<td>19,400</td>
<td>14,290</td>
<td>-5,110</td>
<td>-26</td>
</tr>
<tr>
<td>1 year – 2 years</td>
<td>1,770</td>
<td>5,540</td>
<td>+3,770</td>
<td>+213</td>
</tr>
<tr>
<td>2 years – 5 years</td>
<td>940</td>
<td>1,970</td>
<td>+1,030</td>
<td>+110</td>
</tr>
<tr>
<td>5 years – 10 years</td>
<td>240</td>
<td>1,030</td>
<td>+790</td>
<td>+329</td>
</tr>
<tr>
<td>10 + years</td>
<td>110</td>
<td>370</td>
<td>+260</td>
<td>+236</td>
</tr>
<tr>
<td>Duration unknown</td>
<td>170</td>
<td>1,020</td>
<td>+850</td>
<td>+500</td>
</tr>
</tbody>
</table>

Source: Public expenditure on Health and Personal Social Services, Department of Health Memorandum to the House Commons Health Select Committee, 2005

The number of patients whose duration of stay is over a year has increased by 192 per cent between 1999-00 and 2003-04. Clearly hospital spending has become somewhat more concentrated on a relatively small group of longer stay patients. The balance of funding would be even clearer if it were possible to take full account of the funding of patients in the private sector. Most of these are medium stay patients who may not be fully counted in admission statistics to NHS units. While the intention has been to develop a more community focused service the funding has gone in quite a different direction.

3. Quality of inpatient care

The quality of inpatient care has been rated as low by numerous surveys – most recently by the Sainsbury Foundation and above all in a powerful report by the Mental Health Act Commission.\(^\text{11}\) The service does not operate within the same framework of compulsory standards as the Commission for Social Care Inspection (CSCI) sets for long term care in the private sector. If there had been the same rigour of outside inspections against defined standards for NHS facilities as the private sector, a number of them would have been closed down for failing to meet standards. Even where the physical environment has been improved there is often little positive about the day-to-day therapeutic regime with extended periods of inactivity and boredom.

The Mental Health Act Commission Report – *In Place of Fear* – provides much more definitive evidence on the state of inpatient care than has been available before. It is of great importance because it is based on unique access to the actual conditions in wards all over England. Presenting a picture of great difficulties with staffing, quality of care and rising risk it must cause deep disquiet. The Department of Health response has been a new programme for improving the built environment for inpatient care. We would see this as a totally inadequate response to the depth of the crisis revealed in the report.

In an audit of mental health and learning disability wards the Healthcare Commission found that 23 per cent of respondents reported sharing wards with members of the opposite sex when they did not want to.\(^\text{12}\) This finding contrasts with Government figures showing 98 per cent compliance with guidance on single sex accommodation by mental health trusts.

From 1999-00 to 2003-04 spending on inpatient care at constant prices rose by £600 million (+27 per cent). The number of admissions fell from 200,900 to 171,650 (-15 per cent). Thus spending per admission in real terms rose from £11,200 to £16,600 – a rise of 48 per cent – against a background of increasing concern about the quality of inpatient care.

The service is operated with very high levels of compulsory treatment. The number of detentions under the Mental Health Act rose from 24,811 in 1987-88 to 46,003 in 1998-99. In the most recent year 2003-04 there was 43,847 detentions. Few of these detentions are of elderly people. But what these figures show is that of adults over 65 admitted to hospitals 40-50 per cent are being treated compulsorily with the proportion nearing 70 per cent for patients from ethnic minorities.\(^\text{13}\) Some of this compulsion may be justified by risk – but some of it reflects the difficulty of getting patients to accept treatment on a community basis.

In a long term perspective mental health services have been associated with high levels of compulsory treatment and even though numbers have not


\(^{13}\) *Public Expenditure on health and Personal Social Services*, Department of Health Memorandums to the House of Commons Health Select Committee.
increased in the last few years they have continued to rise in relation to a declining number of new admissions. The great majority of longer term admissions still involve compulsion.
4. Mental health and the social environment

The OECD has noted the growing importance of mental health and in particular its effect upon the economy. It notes that a growing number of incapacity benefit claimants receive it due to reasons related to mental health. In its latest *Economic Survey of the United Kingdom* the OECD stated:

“...In the 1980s and early 1990s, disability benefit recipients were more likely to have had problems with joints and muscles than to have mental and behavioural disorders. But now people with mental and behavioural disorders dominate, their number having grown to a million incapacity benefit recipients today, five times the number in the mid-1980s .... The magnitude of this change raises a large challenge for the health service about how to better help this group with treatment and rehabilitation.”

The below chart is taken from *Economic Survey of the United Kingdom 2005*:

It is vital to assess how new aims, incentives and policies could benefit users to the mental health services. There is a serious danger that mental health services will be left behind in this period of change of the whole of the NHS. The Social Exclusion Unit has also produced a landmark report on mental health and social exclusion, which sets out new policy options for better rehabilitation and for reducing stigma.

Trust and PCT managers in the mental health services are going to have to make sure that mental health services can take advantage of the new policies and incentives in a reformed health service.

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5. **Further problems with the current system**

There has been mixed success in attracting young doctors into psychiatry and many posts remain unfilled or filled by locums. The Royal College of Psychiatrists has set out a clear and positive strategy covering standards, communications and structures. Among the aims in communication are those of increasing collaboration with other healthcare professionals and developing shared organizational goals.

There has been some success in attracting more young people into nursing courses for psychiatric nursing but there may be little success in retaining them to work in the NHS. According to internal health authority reports staff gaps remain large with 13 per cent of nursing posts unfilled on inpatient wards and 22 per cent in the London area. The NHS now faces a more competitive labour market for such staff with competition from the social services and from the private sector.

Mental health services have been associated with continuing levels of social stigma. In fact social attitudes to people with mental illness appear to have worsened over the past four years with surveys showing higher levels of rejection.16

As the NHS enters a period in which patients have more power through choice mental health services start with a history of little choice. Choice should play a role for everyone; even during severe illness there may be choices which are relevant for patients and carers. For the discharge/rehabilitation stage choice surely becomes highly relevant. There have been some real gains in terms of the greater role of user groups but there is still a long way to go to offer choice in type or location of services in housing access or employment rehabilitation.

The use of resources has shown little movement towards more spending on housing or employment access. Nor has there been much development of psychological therapies. Such programmes, which could provide pathways to recovery, have attracted very little of the additional funding which the service has gained over the past three years. Unfortunately, the Government is (still) not joined up across agencies such as housing, social services and health regarding Key Performance Indicators.

For the future, services are now in the position of competing for additional funding without help from compulsory targets. Already according to local NHS reports some mental health trusts such as in Sussex are receiving increases of 5.5 per cent a year which are below the likely level of cost increases. Many are losing funds to cover deficits in acute trusts. A policy brief published by the Department of Health alongside Mental Health Strategies’ 2005-06 **National Survey of Investment in Mental Health Services** found that Strategic Health Authorities have reduced their investment from the

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agreed investment baseline for 2005-06 by £16.49 million, a reduction of 1.9 per cent. Reductions come at a time of increasing costs and are an important sign of how providers are swinging away from mental health services. Mental health services are to face a period of slower growth in spending with much unfinished business. It is difficult to see how trusts can both improve acute care and invest in new services.

6. Recommendations

The Five Year Review presented an optimistic picture of progress but as funding restrictions increase it may be even more difficult to improve the quality of inpatient care and care programmes for patients with the whole range of severe mental illness. It is also very hard to see how with current policies it will be possible to meet the 18 week target for access to psychological and other therapies in the community. We should explore options which would bring results for patients much faster.

The realistic outlook for these services is one in which there is an unusually large gap between funding and expectations. The gap exists in acute services but not to the extent which is now present in the mental health services. The main service changes required are for building up capability for early support in CBT and other community based services and for moving towards care programmes with access to housing and employment for people with severe mental illness. The new services have to be developed over a time of new scarcity in funding indeed when many trusts may expect falling funding in real terms. The reputation of the services is of great inflexibility and difficulty in shifting resources. The record of increased spending on a diminishing number of hospital patients supplies some evidence on this together with numerous critical reports by outside agencies.

However the service also has some new strengths with a new generation of managers and professionals with a highly positive approach compared with the old guard. The wider use of new anti-psychotic drugs are improving the treatment process for many patients so that patients feel better and rehabilitation becomes a realistic option earlier for more patients. There are also many new young staff in nursing, psychology and medicine who have started to work in the services.

There are opportunities to use joint commissioning with social services to draw on the social service experience of identifying new customer needs and using public private partnership to design new services to meet them. There should also be gains from the new Foundation Trusts with greater ability to use investment to develop new services.

The funding outlook is at best one in which funding will remain constant in real terms and it is more likely that many Mental Health Trusts will find their funding shows little increase in cash terms over the next three or four years. This is already happening to some large trusts such as the South West London and St George’s Mental Health Trust.

The new care model with its emphasis on early intervention, community support, reduced admissions and much more help to return to employment is clear enough. There is certainly a lot more consensus around this model than was previously the case. The key issue now is to make it happen in this very difficult funding environment.
Here the reform incentives and systems could be crucial. They are often seen as highly threatening with a strong preference for remaining with the monopoly model: but choice, direct payment and pluralism offer the only realistic way of making progress towards the new kind of care which is there for the making. We would urge the following key first steps.

1. Develop a mixed economy of care in cognitive behavioural therapy and other local preventive services. It was notable that the two pilot schemes in wider cognitive behavioural therapy in Doncaster and Newham were not put out to tender even though there would have been considerable private and voluntary interest in providing for them.18

2. Key use of direct payments both for people needing therapy in the community. This would help to develop the supply of services. There are many professionals at present who wish to do this work but cannot do it because of rationed funding in the NHS.

3. Make much more use of direct payment for patients who are reaching the discharge/rehabilitation stage. Patients can be offered much more choice and can be empowered to follow their own preferences and interests. If the health services are to help the moral issue of how people can re-establish themselves as free and independent individuals with “a job, a home and a friend” – as was well put by a dynamic chairman of a London Mental Health Trust – we must surely give them more choice and more responsibility. Of course carers and their professional supporters are going to be involved in most cases in these choices but patients can start to decide on their own futures. Direct payments can be used for support in moving to accommodation, for employment skills training or for activity which contributes to recovery. It can also be used for paying for support outside hospital.

4. Use of direct payments can be accelerated through joint management with social services. There is already great support for the policy in social services and experience in using them.

5. Develop a strategic partnership with the private and voluntary sector to accelerate investment. The public/private partnership is one which is still based around spot purchasing rather than about a framework for pluralism. Through such partnership it would be possible to replace many of the existing hospitals with new care centres which would serve the new model of care. These new centres would include inpatient care but on a much shorter stay basis and they would provide much greater privacy and much more continuous support. Some of these centres would be provided by voluntary and private providers within common standards for quality. With such a strategic partnership it would be possible to bring about a substantial change in

18 End of the ‘prozac nation’ – more counselling, more therapy, less medication to treat depression, Department of Health press release, 12 May 2006.
three years, especially as the change could unlock some of the large property assets which are within the existing hospital system. The new generation could design the services to fit the new model of care and to reflect the greater power of patient choice.

6. Introduce a much more active commissioner/provider relationship. To some extent mental health services have been the area which the internal market forgot. Now joint commissioning with social services supplies a chance for a more effective use of the new incentives. The introduction of payment by results is essential and it is one sign of the recoil to monopoly that the introduction has been postponed yet again. More active commissioning is already achieving significant results in demand management through reducing admissions—increasing even more the requirement for flexibility and care programmes in the community.

This action plan is already being followed in a number of areas such as Telford and Peterborough and supplies the only realistic chance of bridging the large gap between aspiration and funding.
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