King's Fund | Report

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London's State of Mind

KING'S FUND MENTAL HEALTH INQUIRY 2003

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ROS LEVENSON
WITH ANGELA GREATLEY AND JANICE ROBINSON

King's Fund
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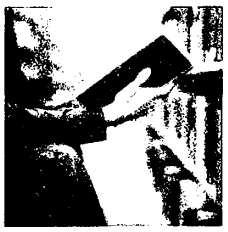

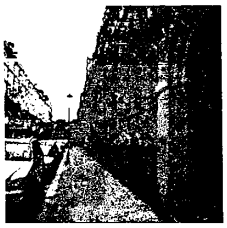

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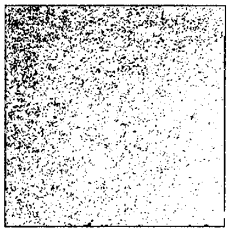
About the authors

Ros Levenson is a visiting fellow at the King's Fund and an independent researcher and policy consultant, mainly working with the NHS and the voluntary sector She has published widely on a range of health and social care issues. Ros's early career was in social work and social services training. Her interest in health service issues, and particularly health inequalities, developed during ten years as a community health council member, and she later became Director of the Greater London Association of Community Health Councils – a post that she held for five years. Ros is currently a non-executive director of an NHS trust.

Angela Greatley is Director of Policy and Research at the Sainsbury Centre for Mental Health. Formerly Fellow in Mental Health at the King's Fund, Angela has worked on topics including primary care and mental health development, equalities issues in mental health, and assertive outreach and social inclusion. Angela has been an advisor to the House of Commons Health Select Committee and formerly worked within the NHS, as a provider manager, and at a regional health authority, where she worked on the community care programme. She was subsequently a director of commissioning in a London health authority. Angela has also been a local authority councillor and was a chair of social services. She is currently a governor of a large further education college.

Janice Robinson is Senior Adviser, Health and Social Care at the King's Fund. She has lead responsibility for analysing the development and implementation of health and social care policies as they affect people with long-term illness or disability. Janice has directed research and service development programmes related to ageing, disability and mental health. She has authored publications focusing on community care reforms, support for carers, regeneration and mental health, long-term care funding, and age discrimination in health and social care.



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The group met on five occasions during 2002/03. Its members were:

- Professor Elizabeth Anionwu, Head of Mary Seacole Centre for Nursing Practice
- Ms Jennifer Bernard, Director of Services for Children and Young People, NSPCC
- Professor Adrian Eddlestone, Chair Bromley PCT and King's Fund Management Committee
- Ms Alison Faulkner, Service User Consultant and Trainer
- Dr Claire Gerada, GP at the Hurley Clinic, south London
- Professor Hamid Ghodse, Chair, Department of Addictive Behaviour and Psychological Medicine, St George's Medical School
- Sir Graham Hart, Chair, King's Fund Management Committee
- Dr Julie Hollyman, Chief Executive, West London Mental Health NHS Trusts
- Mr Lionel Joyce, Chair, Turning Point
- Professor Martin Knapp, Centre for the Economics of Mental Health, Institute of Psychiatry and LSE
- Dr Matt Muijen, Chief Executive, Sainsbury Centre for Mental Health
- Rabbi Julia Neuberger, Chief Executive, King's Fund
- Mr Cliff Prior, Chief Executive, Rethink
- Professor Graham Thornicroft, Head of Health Services Research Group, Institute of Psychiatry
- Ms Melba Wilson, Institute for Applied Health and Social Policy, King's College.

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Glossary

Acute care forum
In 2002, the Department of Health called for each mental health trust to establish an acute care forum to identify strengths and weaknesses in the acute system, to link the elements of the acute care system, and to ensure effective service co-ordination and delivery of service across inpatient wards (including intensive care) and community teams.

Acute care system
This is the service system provided to support people who are experiencing particularly severe problems – either in the short term, or in a severe phase of a longer-term problem, often referred to as an 'acute episode' or 'crisis'. Care may be provided in a hospital setting or, increasingly, in the community.

Acute inpatient ward
This is an inpatient ward designed to provide humane treatment and care in a safe and therapeutic setting for service users during the most acute and vulnerable stages of their illness.

Assertive outreach team
This is a specialist multi-disciplinary team designed to meet the needs of the small number of people living in the community with severe mental health problems and complex needs who have difficulty in engaging with services, and who often require repeat admissions to hospital. The team provides frequent contact over often long periods of time.

Care programme approach
The care programme approach (CPA) is a framework for care co-ordination for service users who are under the care of specialist mental health services. The main features of CPA are a care co-ordinator, a written care plan, and regular reviews by the multidisciplinary team. The service user should be involved in developing and agreeing the plan. There are two levels of CPA – standard and enhanced – the latter for those with more complex needs.

Commissioning
Commissioning is a process designed to assess the needs of a population, identify the resources and services available, and develop a strategy for making best use of those resources to meet those needs. Commissioning strategies need to be reviewed and amended as necessary on a regular basis.

Community mental health team (CMHT)
This is multidisciplinary mental health team with two broad functions: to offer continuing treatment care and monitoring for people with severe mental health

problems, and to provide support and information about treatment and management to other professionals – principally primary care professionals – working with people experiencing time-limited and common mental health problems.

Co-morbidity
This describes the co-existence of several diagnosed health problems – for example, a mental health problem and a long-term physical health problem. The term is also used to describe severe mental health problems and problematic substance misuse. (*See also* 'Dual diagnosis'.)

Complex needs
See 'Dual diagnosis'.

Crisis house
Crisis houses provide short-term support and intervention for individuals in emotional distress, as an alternative to hospital admission. Crisis houses operate on the social care model of mental health rather than the medical model. Most crisis services will not accept service users who are sectioned under the Mental Health Act, and some may not accept those who pose a significant risk of violence, either to themselves or others. (*See also* 'Medical model', 'Social care model'.)

Crisis resolution team
This is a specialist multi-disciplinary mental health team offering treatment, care and support to people with severe mental health problems suffering an acute crisis. Working to maintain people in the least restrictive environment – usually the person's home – the team works intensively to treat and resolve the acute problems, and to enable the person to return to their usual level of care.

Dual diagnosis
A person is said to have a 'dual diagnosis' where two co-existing conditions have been diagnosed. In this report, the term is used to describe people with severe mental health problems and problematic substance misuse (illicit drugs and/or alcohol) – also referred to as 'complex needs'. The term is not used to describe the larger group of people with severe mental health problems who may use alcohol or drugs from time to time, or for people with problematic substance misuse who experience a common mental health problem, such as depression or anxiety. (*See also* 'Co-morbidity'.)

Forensic
This term defines the branch of psychiatry dealing with the assessment and treatment of offenders with mental health problems. It is also used more broadly, to deal with the range of services available to them, and to those with mental health problems who exhibit violent or threatening behaviour but may not have committed an offence at that time.

Home treatment team
See 'Crisis resolution team'.

Improving Working Lives
This is a Department of Health initiative that sets a model of good human resource practice against which NHS employers and their staff can measure the organisation's human resources management, and against which NHS employers will be kite-marked. NHS organisations were required to achieve accreditation against the standard by April 2003, demonstrating that they are improving the working lives of staff.

Local implementation teams (LITs)
These are local teams, established in 1999, that work to interpret and implement the National Service Framework for Mental Health in their area. All LITs include representation from health and social care managers, clinicians, statutory and voluntary sectors, professionals, service users and carers.

Low-secure units
Low-secure units deliver intensive, comprehensive multi-disciplinary treatment and care, by qualified staff, for patients with serious mental health problems who demonstrate distressed behaviour and need a secure environment. These units aim to provide a homely environment, with occupational and recreational opportunities, and links with community facilities, with an emphasis on rehabilitation and risk management. Patients are detained under the Mental Health Act, and may be restricted on legal grounds for up to two years.

Medical model
In the medical model of care, symptoms are seen as a result of a disease or illness, and are treated by various medical interventions, such as medication. The model focuses on addressing the symptoms rather than the wider issues around the social and environmental world of the patient. (*See also* 'Social care model'.)

Medium-secure units
Medium-secure units are mainly geared towards forensic mental health. They provide services for people who cannot be managed safely in local environments, as well as some people from prisons and other facilities who have a mental health problem. They provide a level of security suitable for protecting patients and the public. (*See also* 'Forensic'.)

Mental health
Mental health is the balance between all aspects of an individual's life – social, physical, spiritual and emotional. It is an integral part of everyone's overall health. It is more than simply the absence of mental health problems, and relates to many aspects of our lives, including how we feel about ourselves and others and how far we feel able to cope with the demands of life. It is also be referred to as mental well being.

Mental health grant
This grant is designed to fund effective services based on local needs assessment. It is administered through social services, and depends on joint strategies and implementation plans with the NHS.

Mental health promotion
Mental health promotion refers to any action that actively promotes or enhances the mental well being of individuals, families, organisations or communities. It is essentially concerned with how these groups feel, the factors that influence those feelings and the impact this has on their overall state of mind. It plays a role in preventing specific mental health problems, such as anxiety and depression, but also has a wider range of health and social benefits. (*See also* 'Mental health'.)

Mental illness
This terms refers to a significant problem with an individual's feelings, thinking, behaviour and personality, classified by the medical profession. Common mental illnesses include anxiety, depression, schizophrenia and bipolar affective disorder (manic depression). They can encompass a wide range of symptoms and there is a similarly wide range of treatments available. Some people may experience a single episode of mental illness and make a full recovery, while others may have a series of episodes throughout their lives. (*See also* 'Medical model'.)

Mental well being
See 'Mental health'.

Modernisation Fund
The Government set up the Modernisation Fund to support investment to improve public services under its modernisation agenda. In 2000, it committed an extra £700 million over three years to help local health and social care services reshape mental health services. Together with main allocations, this fund provides the resources for the implementation of the National Service Framework for Mental Health over that period.

National service framework (NSF)
The national service frameworks (NSFs) were published by the Department of Health to set national standards and identify key interventions for a defined service or care group. The National Service Framework for Mental Health was published in September 1999. It sets out seven standards in five areas: mental health promotion, primary care and access to services, care for people with severe mental health problems, carers for those with mental health problems, and suicide.

NHS Plan
This is the Government's overarching plan for the health service. Launched in July 2000, it outlines changes to the way the NHS is organised and delivered, and sets specific targets for achievement. It is linked to major investment in increasing numbers of NHS staff and hospital beds, and the quality of specific services.

NHS trust
This is a public body providing NHS hospital and/or community health care. NHS trusts (as distinct from primary care trusts) supply secondary care, including hospital care. NHS mental health trust services typically include adult mental health services, psychotherapy, mental health care for older people, clinical

psychology, forensic services and child and adolescent mental health services. Community mental health teams are jointly commissioned with local social services departments.

Performance indicators
NHS performance indicators are published statistics showing how NHS organisations are performing in specific areas, in order to provide comparisons and improve performance overall. They highlight where organisations have done well and poorly, and where improvements are necessary. They cover services such as treatment for heart disease, cancer and mental health.

Primary care
This is the first point of contact for most patients with a health problem. Primary care services are generally provided through GP practices, and may involve other health professionals such as practice nurses and counsellors. They also include dentists, pharmacists, opticians, district nurses and other services. Primary care is provided locally, near to where patients live – often in the local high street, or even in patients' own homes.

Primary care trust (PCT)
A primary care trust is a statutory body responsible for delivering healthcare to its local population. PCTs were established under the Health Act 1999. They have their own budget, allocated by the Department of Health, for local healthcare, and are able to employ staff and develop new integrated services for patients. They commission both primary and secondary care local health services. They may also directly provide a range of community health services themselves.

Psychiatric intensive care unit (PICU)
This service is provided in highly structured locked units, usually of between six and 15 beds. Psychiatric intensive care units provide for people whose level of distress cannot be safely managed on open acute inpatient wards. All very acute inpatient facilities should have an identified PICU in their area.

Secondary care
Patients whose needs are too complex to be managed in primary care are referred to more specialist services, known as 'secondary care'. This typically involves treatment provided in a hospital setting, although people may be outpatients (not residing in the hospital). It can also be provided in community settings. (*See also* 'NHS trusts'.)

Social care model
In this care model, care and treatment are designed around the overall needs of the patient and their convenience, and patients are fully consulted. The patient is viewed as a whole person – not just an illness – who exists within an extended social and environmental framework of personal relationships, emotions, intellect, life experiences and physical condition. (*See also* 'Medical model'.)

Social class categorisation
For many years, social class based on occupation was categorised as follows:

I Professional etc. occupations
II Managerial and technical occupations
III (N) Skilled occupations (non-manual)
IV (M) Skilled occupations (manual)
IV Partly skilled occupations
V Unskilled occupations

However, it is now becoming more common to use the Standard Occupational Classification 2000 (SOC 2000) which lists the following groups:

1. Managers and senior officials
2. Professional occupations
3. Associate professional and technical occupations
4. Administrative and secretarial occupations
5. Skilled trades occupations
6. Personal service occupations
7. Sales and customer service occupations
8. Process, plant and machine occupations
9. Elementary occupations.

Further information on SOC 2000 is available at:
www.statistics.gov.uk/methods_quality/ns_sec/soc2000.asp

Stakeholders
This term refers to anyone with an interest in the way services are delivered, including service users, carers, patients, service providers, staff, health professionals, and partner organisations such as social services, housing and training agencies.

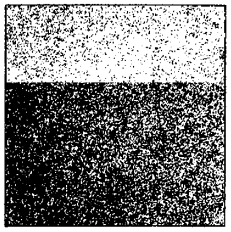
Strategic health authority
Strategic health authorities were created in 2002 as part of the Government's policy outlined in *Shifting the Balance of Power*, which aimed to devolve NHS decision-making to the most local level, via primary care trusts (PCTs). Their role is to provide a strategic framework to co-ordinate the development of health services across their areas, to manage hospital and PCT performance, and to improve the quality and quantity of services.

Supporting People
Supporting People is a government initiative launched in 2001 aimed at improving support services to a wide range of vulnerable people, and ensuring that they have the opportunity to live more independently. Through working partnerships with local government, service providers and support agencies, it promotes housing-related solutions that complement available care services and support independent living. It also introduced a simpler funding stream for commissioning services.

Tertiary care
This term describes specialist services providing complex care, often in specialist hospitals or departments, although it can also refer to some specialist services and care outside hospital. Patients are usually referred to tertiary care by consultants rather than GPs.

Whole-systems approach
A 'whole-systems' approach recognises that effective delivery of health and social care requires planning and service provision extending beyond conventional organisational boundaries. For example, care and support for people with mental health problems involves not just health and social care authorities, but also housing, employment, benefits and environmental agencies. Inter-agency working, providing a range of co-ordinated services to individuals, lies at the heart of the approach.

Workforce development confederations
These organisations were established in 2001. There are 27 confederations in England, with the remit to create local integrated programmes for developing the existing and future workforce needs of the health and social care sector – including the mental health workforce. They are currently working alongside strategic health authorities, but as from 2004 their work will be subsumed by the strategic health authorities.



Abbreviations

A&E	accident and emergency
ACHCEW	Association of Community Health Councils for England and Wales
BME	black and minority ethnic
CHAI	Commission for Healthcare Audit and Inspection
CHC	community health council
CHI	Commission for Health Improvement
CMHT	community mental health team
CPA	care programme approach
CPPIH	Commission for Patient and Public Involvement in Health
CSCI	Commission for Social Care Inspection
DHSC	Directorate of Health and Social Care
FHSA	family health service authority
GLA	Greater London Authority
GLC	Greater London Council
GMS	general medical services
GOL	Government Office for London
GP	general practitioner
HA	health authority
HASCAS	Health and Social Care Advisory Service
HRG	healthcare resource group
ICAS	Independent Complaints Advocacy Service
ILD	Index of Local Deprivation
LIP	local implementation plan
LIT	local implementation team
LIZ	London Implementation Zone
MHAC	Mental Health Act Commission
MINI	Mental Illness Needs Index
NASS	National Asylum Support Service
NCSC	National Care Standards Commission
NIMHE	National Institute for Mental Health in England
NSF	National service framework
NSF-MH	National Service Framework for Mental Health
NTASM	National Treatment Agency for Substance Misuse
ODPM	Office of the Deputy Prime Minister
OSC	overview and scrutiny committee
PALS	Patient Advice and Liaison Service
PCG	primary care group
PCO	primary care organisation
PCT	primary care trust
PMS	personal medical services
PPI	patient and public involvement
SSI	Social Services Inspectorate
StBOP	*Shifting the Balance of Power*
StHA	strategic health authority
TPP	total purchasing pilot

[illegible]

National Institute of [illegible]

Patient Advice and Liaison S[illegible]

primary care group

primary care organisation

primary care trust

[illegible]

Summary

In 2002, the King's Fund commissioned a major inquiry into the state of the capital's mental health and mental health services and how far they meet the needs of service users. The inquiry set out to:

- investigate whether mental health care had improved in the capital since the King's Fund 1997 inquiry, *London's Mental Health*, expressed serious concerns about services under extreme pressure
- identify what improvements had taken place
- identify continuing areas of difficulty and why they exist
- identify what additional measures might improve the mental health of Londoners.

London's State of Mind brings together the results of that investigation. It offers a comprehensive overview of substantial changes that have taken place since 1997 in the policy environment and in the organisation and delivery of services. It also identifies the characteristics of the capital's population that pose particular challenges and opportunities for London's mental health and mental health services.

The report draws on a series of working papers, commissioned to explore areas where information was felt to be lacking, along with consultations with service users, carers and key stakeholders.

Main findings

Enduring problems in mental health services

- **A mixed picture** The 2003 mental health inquiry found that, as in 1997, the picture of London's mental health services – and people's experience of using them – remains very mixed. There are many examples of good services and practice, but the problems and challenges identified in the first inquiry persist to a large degree – despite efforts to address them.

- **Slow modernisation** Modernising mental health services has been a key strand of government health policy since it came to power in 1997. The Government has introduced the National Service Framework for Mental Health (NSF-MH) and committed £700 million for improving mental health services, as well as additional funds for the NHS as a whole. The National Service Framework sets standards spanning the whole spectrum of mental health needs, puts primary care at the heart of the system and emphasises the importance of 24-hour access. Yet London appears to remain locked into using high levels of acute inpatient beds for people with mental health problems, with vitally important community and primary care services remaining underdeveloped in many areas. A disproportionate emphasis on dangerousness and risk has meant that much of the early investment of modernisation monies has been concentrated on secure services. This has inevitably deflected attention from the continuing development of the very services that can help people stay out of hospital.

- **Hospitals under pressure** Compared with other parts of the country, London has a higher proportion of acute inpatient beds for people with mental health problems, and experiences higher occupancy rates. There has been a sharp increase in medium-secure and low-secure beds in particular, with the number almost doubling in five years. The report links the high use of inpatient beds with:
  - high level of compulsory admissions. London has twice as many formal admissions under the Mental Health Act in comparison to any other region in the country
  - a shortage of appropriate community mental health services. For example, only one-third of local implementation team areas in London have a crisis resolution service, which is significant as these services have been shown to reduce hospital admissions
  - a large, apparently increasing proportion of people with dual diagnosis (problematic drug or alcohol misuse together with mental health problems). A recent study indicated that half of the people with psychotic illness in London's acute inpatient beds were also substance misusers.

- **Poor atmosphere and environment on acute wards** In spite of redevelopment and environmental improvements to some acute wards, other wards and services remain in unsuitable buildings. Acute wards are sometimes seen as having a poor atmosphere, with some seen as unsafe and unattractive by staff and service users alike. There is a need to address violence and aggression on the wards and to tackle the challenges posed in London by the very high number of people with dual diagnosis. It is also essential to address the pressures that impede the delivery of care in a calm and peaceful environment and undermine the ability of staff to give the best possible care. African-Caribbean service users and women continue to be concerned about their treatment and care on acute inpatient wards, with some fearing for their own safety.

Little support for day-to-day living

- **Inadequate health promotion** The introduction of a standard for mental health promotion in the National Service Framework for Mental Health has been a positive step. However the inquiry found insufficient attention and resources at a local level for the promotion of good mental health or the prevention of mental health problems, or to enable people to with mental health problems to live their lives as fully as possible. Employment and housing are crucial issues in promoting and maintaining good mental health, yet the inquiry heard that service users found enormous problems in securing these necessities. Regeneration and other urban renewal schemes could tackle these issues with greater vigour, but few are prioritising mental health promotion. At a national level, while some policy initiatives (such as attempting to reduce child poverty) may be expected to promote better mental health, other policies (such as those relating to asylum seekers) may contribute to increased stress and exacerbate mental health problems among vulnerable people.

- **A shortage of appropriate housing** While demand has grown in London, the supply of suitable housing with appropriate support for people with mental

health problems has remained static. Funding, staffing and staff training do not appear to have kept pace with the increasingly complex needs of people in London with mental health problems. The development of the Government's Supporting People programme is welcome and positive, as it will greatly improve planning, funding and monitoring of housing support services. More needs to be done, however, to ensure the right priorities for offering specialist accommodation and support, and to ensure that funding for Supporting People, and for health and social services, is co-ordinated and sufficient.

Barriers to progress

- **Weak commissioning** Weak commissioning of mental health services by primary care trusts emerged as a key factor in the slow pace of modernisation of London's mental health services. The inquiry found:
  - primary care trusts in the capital, which are relatively new, under-developed and numerous, had insufficient influence and leverage over the relatively small number of large mental health trusts that provide the services
  - duplication of effort, with expertise in commissioning mental health services thinly spread
  - gaps in provision and variations in quality and provision (unrelated to need), suggesting that mental health services in London are inadequately performance managed.

- **Problems with tracking funding** The inquiry found it difficult to track the pathway of funds allocated to mental health in London, and therefore could not clearly establish whether a lack of resources had hampered the modernisation of services. It is estimated that spending on mental health care by London's NHS had grown by 14 per cent since 1997. But this is only half of the 28 per cent increase in expenditure in the NHS as a whole, and much of it will have funded secure inpatient services rather than community services. There are also wide variations in spending across London that cannot all be explained by variations in need or levels of service.

- **Staff shortages** London's NHS workforce shortages are particularly severe in some parts of the capital's mental health services. In acute wards, in particular, London's mental health staff face a demanding workload, linked to the capital's high levels of dual diagnosis and detained patients. All nurses interviewed by the inquiry said they had felt concerned for their personal safety at work at some time. Staff often believe that more worthwhile work is to be found on community teams and in low-secure and medium-secure facilities. This results in a disproportionately high staff turnover and a high use of junior and temporary staff on acute wards.

- **Stigma and prejudice** Mental health service users feel that that the focus by the Government and the media on risk and dangerousness add to the stigma and prejudice they experience. The debate on the Government's draft Mental Health Bill in 2002/03 coincided with worsening public attitudes towards people with mental health problems.

An underlying problem

- **London is special** London is unlike other cities in the UK because of its size, resources and the challenges it faces, as well as the opportunities it offers to those who live and work there. Unlike Birmingham or Manchester, it is not governed by a single body, and there are particular challenges in achieving co-ordination and co-operation across areas and between services. London's NHS structures and systems for commissioning and delivering services are complex, with 31 primary care trusts (PCTs) and five strategic health authorities.

These factors may explain the fragmentation and patchy development of London's mental health services, since a broader framework of solutions is needed than individual PCTs, trusts and London boroughs working with the Greater London Authority can offer.

Recommendations

Developing a strategic approach for London

- ☑ A London mental health strategy should be developed, involving all stakeholders and working in close collaboration with existing London-wide organisations and with relevant voluntary organisations. This strategy would consider the implementation of the National Service Framework for Mental Health across London, as well as the co-ordination of efforts to address those issues that need a London-wide approach (for example, aspects of housing and workforce issues). However, for mental health service provision, the strategy should be built from the bottom to reflect local needs and address local problems.

- ☑ The strategic health authority in London that has the lead on mental health (currently North West London Strategic Health Authority) needs to co-ordinate the development of London's mental health strategy, with the Department of Health ensuring that the effectiveness of this arrangement is kept under review.

- ☑ Central government and strategic health authorities must agree clear arrangements to ensure accountability for the implementation of London's mental health strategy.

Strengthening commissioning in London

- ☑ PCTs, in co-operation with their local authority partners, need to identify a lead PCT in each strategic health authority to undertake those aspects of commissioning that would benefit from sector-wide commissioning.

- ☑ Strategic health authorities must take responsibility for ensuring that lead commissioning arrangements are in place and for resolving disagreements between PCTs on commissioning decisions and priorities.

- ☑ Each PCT, in co-operation with its local authority partners, should retain the responsibility for assessing local needs and ensuring that they are being met, and commissioning small-scale services to meet very specific local needs. However, detailed work on service specifications and the contracting process would best be undertaken by the identified lead commissioner on behalf of the other PCTs in the sector.

- ☑ Given that commissioning is still a new and developing skill, the London Development Centre for Mental Health needs to work with the King's Fund and other developmental and educational bodies to establish a Centre for Excellence in Commissioning as a resource for commissioners.

Advancing performance management

- ☑ Strategic health authorities need to strengthen their performance management of mental health services in London, with an emphasis on achieving equity in relation to need in services across London in the context of a London mental health strategy.

Improving service delivery

- ☑ Mental health trusts and PCTs in London, together with their local authority partners, need to further develop community services across London, focusing especially on services for which there is good evidence of effectiveness.

- ☑ The National Institute for Mental Health in England, through the London Development Centre for Mental Health, must work with other relevant organisations to improve support for providers of mental health services in London and to facilitate access to support and development, especially for those in a leadership role in mental health.

- ☑ Mental health trusts need to review conditions, staffing levels and skill mix in acute inpatient wards, instigating measures to improve the status, rewards and support for ward staff, and to improve the ethos of acute wards for the benefit of staff and service users alike. This is especially important where the incidence of co-morbidity and dual diagnosis among service users makes providing safe and effective services most challenging.

- ☑ Mental health trusts must prioritise training on dual diagnosis and complex needs for staff in London's acute inpatient wards.

- ☑ To complement local work on improving acute care, central government should commission an independent, systematic review of acute inpatient care provided for black and minority ethnic service users, to address concerns about safety and appropriateness.

- ☑ Mental health trusts and PCTs, in co-operation with their local authority partners, need to take urgent action to commission and provide a range of services to meet specific needs of black and minority ethnic service users, especially women.

- ☑ Mental health trusts, PCTs and their local authority partners should work more closely with service users and carers and their organisations, which must be empowered to play a major part in making change happen. Their progress in doing so should be scrutinised by the Commission for Healthcare Audit and Inspection (CHAI) in the course of its reviews.

- ☑ Mental health trusts need to extend opportunities for shared learning between acute inpatient staff, staff in community mental health teams, and staff in assertive outreach and crisis services.

- ☑ The appropriate royal colleges, workforce development confederations (and strategic health authorities, when they assume responsibility for the work of workforce development confederations in 2004), and other bodies responsible for the education and training of primary care professionals must ensure that primary care professionals are better trained, resourced and supported to offer high quality care to people with mental health problems. This should include those with less serious mental health problems who use primary care but are often seen as less of a priority by specialist services.

- ☑ PCTs and strategic health authorities must recognise primary care mental health services as an essential part of the range of services for people with mental health problems, alongside specialist mental health services.

- ☑ PCTs need to identify a budget for primary care mental health services, to support the implementation of the NSF and NHS Plan targets.

Tackling the housing need

- ☑ Local authorities, in co-operation with PCTs, need to undertake strategic assessments of local needs, taking into account shortfalls in provision and shortcomings of existing accommodation and service models, as well as the needs of people with dual diagnosis and complex needs.

- ☑ The Office of the Deputy Prime Minister (ODPM) must work with key London-wide statutory and voluntary organisations to agree an action plan for housing for people with mental health needs in London. This would include ordinary, permanent housing for people with mental health needs.

- ☑ Local authorities and other housing providers must work with black and minority ethnic communities and agencies to develop models of good practice in meeting the housing needs of mental health service users from those groups, across London.

- ☑ The Department of Health and the ODPM should work together to introduce a single database of mental health provision in London incorporating the new Supporting People database, registered care, and other health and social services provision. This should be used to develop mental health and housing strategies to feed into future Supporting People planning.

- ☑ Local authorities and housing providers need to do more work on ways to help mental health service users find and keep suitable housing. The Social Exclusion Unit could usefully consider housing for mental health service users as a factor affecting employment in its forthcoming work on mental health and social exclusion.

- ☑ The Housing Corporation, housing associations and Supporting People teams should gather and publish models of good-practice approach that combine the provision of housing and support for people with mental health needs with affordable housing for key workers.

Promoting mental health

- ☑ The Health Development Agency needs to work together with relevant bodies to agree on a definition of mental health promotion, and to indicate which approaches, interventions and activities should be developed, so they can be costed and evaluated properly.

- ☑ NHS bodies, local authorities and other relevant public bodies should assess emerging new policies at the development stage, to avoid social exclusion and other possible negative effects on the mental health of communities.

- ☑ Local strategic partnerships must ensure that neighbourhood renewal and regeneration programmes contribute as fully as possible to improving the mental health of communities.

- ☑ The royal colleges and universities, alongside other educational establishments responsible for the education and accreditation of training of health and social care professionals, should provide education and training on mental health promotion. This would sit alongside more conventional courses on providing care to people with mental health problems.

- ☑ Central government, NHS bodies and local authorities need to recognise the important contribution of voluntary organisations in promoting mental health, and should identify a range of measures, including capacity building and more secure funding, to enable them to develop this aspect of their role.

- ☑ Local implementation teams must ensure that they have appropriate and strong stakeholder involvement that will enable them to deliver better mental health in local communities.

Addressing finance

- ☑ The Department of Health and primary care trusts must develop a better and more transparent system for tracking the use of funds intended for mental health, ensuring that they are targeted at assessed needs and are not used to set against deficits in other services. The system must allow valid comparisons to be made across PCTs.

- ☑ Strategic health authorities, with the help of PCTs and their local authority partners, need to examine the reasons for the variations in spending across London on mental health, and consider whether they need to make changes so they can invest in services for which there is a need and evidence of effectiveness.

- ☑ The Audit Commission should examine levels of expenditure on mental health as part of its reviews of PCTs and mental health trusts.

Making data and information available

- ☑ Central government, in co-operation with the strategic health authorities, should take stock of what information is available, and should state what information is needed about mental health services and spending – in particular, scrutinising how it is collected and presented in relation to how

it will be used. Data should be collected in a way that enables comparisons across London, and in relation to other parts of the country. There needs to be a clear audit trail for the use of funds intended for mental health.

Meeting the workforce challenges

- ☑ The workforce development confederations (and strategic health authorities, when they assume responsibility for the work of the confederations in 2004) need to work together to develop a strategy for action to address the challenges facing London's mental health services. This should link in to the London-wide mental health strategy, recommended in Chapter 11.

- ☑ The workforce development confederations (and strategic health authorities) need to take responsibility for compiling robust data specifically relating to the mental health workforce in London. A minimum dataset to inform the routine and mandatory collection of workforce data across the specialties should be introduced as a matter of urgency.

- ☑ A named person in each workforce development confederation (and in the strategic health authorities) should take responsibility for helping refugee workers to enter the workforce in mental health and other services.

- ☑ A named person in each workforce development confederation (and in the strategic health authorities) should take responsibility for increasing the recruitment and retention of mental health service users as workers in London's mental health services.

- ☑ Mental health trusts should review the pressures on the workforce on acute wards, with a view to better training and support for that section of the workforce.

- ☑ Workforce development confederations (and strategic health authorities) should co-ordinate the collation and dissemination of good practice in recruiting and retaining staff and, liaising with mental health trusts and the London NHS human resources managers' network, should provide development opportunities for all trusts to learn from the experiences of the most successful trusts.

Part 1
Background

1 Introduction

The introduction sets out the aims of the report, and of the 2003 King's Fund mental health inquiry. It provides an overview of the findings of the previous King's Fund mental health inquiry, in 1997. It then goes on to explain the process of the present inquiry, detailing its key activities, including commissioning working papers, and conducting consultations with service users and professionals working in the mental health field. Finally, it explains how to use the report.

1 Introduction

This report presents an overview of the findings of an inquiry into mental health in London, conducted by the King's Fund in 2003. The inquiry was set up to look at mental health and mental health services in London, with the stated aim of tackling some old questions about the mental health and mental health care of Londoners.

These 'old questions' had been addressed in depth in an earlier inquiry into London's mental health services, *London's Mental Health* (Johnson *et al* 1997), written by a group of experts in the mental health field as part of the work commissioned by the then King's Fund London Commission. The key findings of this earlier inquiry were incorporated into *Transforming Health in London* (King's Fund London Commission 1997), and part of the brief for the 2003 inquiry was to revisit these findings five years on.

In 1997, there was a change of government, and since then, there has been a proliferation of policies and initiatives that impact directly and indirectly on mental health. The big question that has remained unanswered is: are things getting better or worse for Londoners? It seems a simple question, but it is not easy to find some of the answers. On the one hand, there are reams of information and stacks of statistics about mental health and mental health services in London, but on the other, much of the data available is incomplete or inconsistent. For example, it can be surprisingly difficult to work out how much money is spent on mental health services in London, and what it is spent on.

What were the findings of the 1997 inquiry?

Findings from 1997 described an inner-London mental health service 'that cannot be sustained' (Johnson *et al* 1997, p 1). It also noted that across the capital, 'no single service appeared to have a full range of desirable features' (*Ibid*). The prophecy of doom about unsustainable services may have been overstated, but in 2003 there is probably still not one service that has all the desirable attributes.

The key findings of the 1997 inquiry were as follows:

- There were very high levels of mental health problems in London, and the position was particularly extreme in inner London.
- The level of need created a huge demand for mental health services.
- The services that were available were under extreme pressure.
- There were gaps in the care that was provided, with a pressing need to create more innovative and responsive community-based services, as well as rehabilitation facilities for people with longer-term problems and beds for people who had acute problems.
- Where treatment was available, there were long delays.
- Some groups of Londoners were particularly poorly served, including children and young people, people with severe and long-term mental health problems, and Londoners from black and minority ethnic groups.

The big question that has remained unanswered is: are things getting better or worse for Londoners?

Has progress been made towards introducing measures that support the mental health of Londoners?

The 1997 inquiry raised important questions about the funding of London's mental health services, and the considerable 'systems' problems that appeared when mental health, primary health care, social care and other agencies had to work together. The problem of inefficient joint working was borne out by evidence from various inquiries into problems relating to homicide and suicide by people with severe mental health problems.

The 1997 report summarised six key points raised by users themselves:

- Users often faced problems in obtaining good information.
- Users experienced a lack of help with ordinary living, such as finding and maintaining housing, getting help with personal finances, and in getting a job.
- Users needed support with personal growth and development.
- Getting the right kind of help in a crisis was a critical problem.
- There was limited forward planning.
- Well co-ordinated packages of treatment, care and support were much needed.

The report argued for a range of changes, and was particularly forceful in recommending that if the high level of demand for services were ever to be stemmed, London needed to understand and tackle the underlying causes of mental health problems. It argued for improved services, based on clear, shared local joint plans. It also argued that the development of these plans must involve people who actually used the services, alongside their families and carers. The report recommended that funding formulae should be adjusted to reflect the severity of London's mental health problems, and that attention be given to staff shortages and the need for improved training.

What was the remit of the 2003 inquiry?

London's Mental Health was a well-regarded and influential document, and many of the changes that have taken place since its publication are consistent with its recommendations. However, it is abundantly clear that many problems remain – and that while many of the key policy developments and innovations that have taken place are sound, implementation of changes has been uneven. Mental health professionals, and mental health service users and their carers, all agree that although positive changes are evident in many service areas, many of the problems identified in 1997 still persist.

The principal question that the 2003 inquiry addressed was: have London's mental health services improved in the last five years, and, assuming there has been change, what accounts for the improvements and for the remaining areas of difficulty? A number of related questions follow on from this, including:

- Are the characteristics of London's population different (both from those of 1997, and from those of populations elsewhere in the UK), and what implications does this have?
- How has policy changed, and do professionals, users and carers broadly support the direction it has taken?
- Have policy changes improved services for users of primary, secondary and tertiary mental health services respectively?
- Has progress been made towards introducing measures that support the mental health of Londoners?

- Have mental health services taken steps to invest in new ways of working that will promote good mental health?
- Are agencies working more closely together – and if so, has this led to better integrated services and beneficial change?
- Is the financial investment in mental health deployed to best effect, and has funding for mental health increased over the past five years in line with national policy announcements?
- Is there an adequately trained and appropriately skilled workforce to deliver services, and to bring about improvements, both in service provision and in the mental health of the community?
- Do managers have access to the right kinds of information to help them to manage and make improvements?

How did the inquiry work?

Working papers

The questions set out above were all considered in the course of the inquiry, although the availability of data, and the differing nature of each of the questions, impacted on the depth to which each question could be explored. To address these questions, the King's Fund commissioned a number of working papers to provide up-to-date information on various aspects of mental health and mental health services. These included a number of mental health inquiry (MHI) working papers, which have either been published in print form or are on the King's Fund website at: www.kingsfund.org.uk. The papers are listed below in the order in which they are published. Full bibliographic details are provided in the Bibliography, p 163.

2003 MENTAL HEALTH INQUIRY – WORKING PAPERS

MHI Working Paper 1: *Promoting Health, Preventing Illness: Public health perspectives on London's mental health* (Heer and Woodhead 2002)
Effective promotion of mental health and well being requires co-ordinated activities designed for communities, families and individuals, but little is known about the current state of mental health and well being promotion in London. This paper seeks to fill that gap, drawing evidence from three case study projects promoting mental health and well being, and from primary research. The paper looks at the development of local mental health and well being strategies and considers how far the needs of vulnerable groups are being addressed.

MHI Working Paper 2: *Mental Health Services in Primary Care: A review of recent developments in London* (Rosen and Jenkins 2003)
In the past five years, there have been a number of important changes in the clinical, professional, organisational, financial and policy contexts in which primary care mental health services are provided. This working paper identifies improvements in the overall quality of services, and looks at the distribution of these services across the capital. It identifies a number of factors that place constraints on further improvements, including recruitment and retention problems, organisational turbulence, managerial capacity and funding, and outlines further changes that are needed to ensure consistent quality of service across London.

continued on p 8

The working papers went through a process of consultation and checking, with service users, carers, health professionals and service managers.

continued from p 7

MHI Working Paper 3: *Housing for Londoners with Mental Health Needs: A review of recent developments* (Boyle and Jenkins 2003)
Secure and appropriate housing can play a major role in stabilising the lives of people with mental health problems. This working paper looks at trends in the provision of specialist housing by housing associations for Londoners and considers how well tenants with mental health problems who also have drug and/or alcohol problems are served. It looks at the variations in different parts of the capital, and puts forward proposals for a more co-ordinated approach to tackling London's mental health problems.

MHI Working Paper 4: *London's Mental Health Workforce: A review of recent developments* (Genkeer *et al* 2003)
Across the NHS, recruiting and retaining staff in sufficient numbers remains a major challenge. Within mental health services, the workforce is getting older, violence and harassment can cause problems, and heavy workloads are common. This working paper argues that specific measures are needed to improve the working environment for acute mental health nurses in particular, and that co-operation across a range of agencies in health and local authorities will be needed if change is to be taken forward.

MHI Working Paper 5: *Ethnic Diversity and Mental Health in London: Recent developments* (Keating *et al* 2003)
This working paper provides a snapshot of the changes in services for BME users over the past five years. It offers reflections on the current situation for these communities in London and points to continuing problems in the care and support that they receive. It shows the needs and rights of vulnerable groups such as asylum seekers remain poorly understood, while other groups are significantly under-utilising services. It argues that London's mental health services must reach out more effectively to the city's wide range of diverse communities and offers a discussion of implications for the future.

MHI Working Paper 6: *Financing Mental Health Services in London: Central funding and local expenditure* (Aziz *et al* 2003)
This working paper examines trends in expenditure on health in London and queries variations in expenditure across the capital, comparing this expenditure with increases in NHS expenditure as a whole. It identifies wide variations in expenditure across the capital that cannot be explained by variations in need, and discusses how modernisation monies intended for mental health service in the capital are being allocated and used.

MHI Working Paper 7: *Mental Health Service Activity in London: Recent developments* (McCrone 2003)
This working paper describes trends in mental health service provision since the 1997 King's Fund mental health inquiry. It makes comparisons between the current situation in London and the other NHS regions, and between levels of service provision within different parts of London. It looks at how far services have followed the recommendations set out in the National Service Framework for Mental Health and finds that while assertive outreach teams have indeed been developed in most areas, crisis teams are still largely lacking. The relatively slow development of new community services stands in marked contrast to the dramatic increase in numbers of secure beds.

The 2003 MHI working papers went through a process of consultation and checking, with service users, carers, health professionals and service managers participating at events to discuss the findings on each topic. This report makes extensive use of the working papers, and they are referenced throughout the text. A background paper about the distinctive features of London's population was also prepared to inform the inquiry.

It would not have been possible in the time available to commission new work on every aspect of mental health services and on all the other issues that affect mental health and mental health services. The selection of working paper topics was guided by a need to bring together information from disparate sources, or to update knowledge – for example, by carrying out new research on specific areas, such as mental health commissioning by the new primary care organisations. Where it was felt that good intelligence was readily available, new working papers were not commissioned.

In most instances, these decisions were sound. However, with hindsight, there were some additional areas in which new work would have been useful, such as:

- employment opportunities for people with mental health problems
- prisons and mental health
- the role of the voluntary sector in London's mental health services.

Other important areas were considered too complex to be subsumed within this project, and would possibly merit a separate inquiry. These included the controversial issues relating to people with personality disorders and borderline personality disorders. Nor did it look at issues around children, adolescents and older people with mental health problems.

In short, no single inquiry could or claim to be the 'last word' on mental health services in London, and this report sets out some major findings and conclusions in full knowledge that more work needs to be done to build on and update the story so far.

Including service users

A particularly important aspect of the inquiry was the emphasis throughout on seeking and including the views and experiences of service users, and their carers. Invitations were sent to all the mental health voluntary groups in the capital, and some national groups with London networks, asking them to help us make contact with people who had direct experience of mental health services over the preceding five years. Those who responded were invited to participate in one of a series of small discussion sessions. Participants were guaranteed anonymity, and that is reflected in this report. The groups were attended by King's Fund staff, and were expertly facilitated by an independent facilitator.

Between late September 2002 and the end of January 2003, 30 service users and carers from different areas of the capital and from different communities (including some representatives of black and minority ethnic organisations) participated in five groups, to discuss their views about challenges and progress across London.

The difficulty of obtaining London-wide user views is well recognised, and the London Development Centre of the National Institute for Mental Health in

England (NIMHE) has employed a service-user development manager specifically to help to develop a London-wide user voice. However, although the number of participants was not large, many of them were active in groups of mental health service users, and were able to bring in the experiences of other people as well as their own. This aspect of the inquiry provided a qualitative flavour of a range of user views, rather than offering a systematic, quantitative survey of user views from across the capital.

Other consultations

An additional discussion group was held for voluntary organisations, some of whose staff also attended the service user and carer sessions. The voluntary groups were invited to submit any information that they had collected about mental health and mental health care in London over the preceding five years.

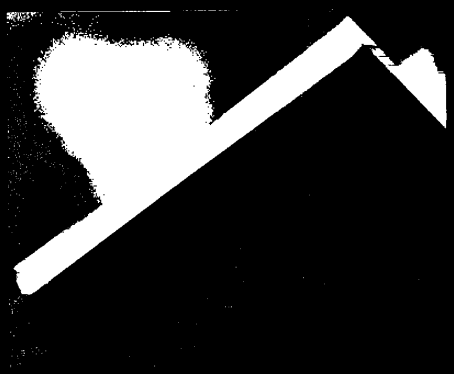
Professional staff were also consulted. Representatives of the Royal College of Psychiatrists, the Royal College of Nursing and the College of Occupational Therapists all participated in an informal discussion, managed by an independent facilitator. The points raised by service users and carers served as the basis for discussion.

Finally, the inquiry had the benefit of a steering group (*see* Acknowledgements, p xiii), which met five times over the course of the inquiry. The members' combined wide experience of mental health issues, enabled the steering group to guide and support the researchers and writers who worked on the inquiry.

About this report

This publication is a thematic report of the main findings of the King's Fund 2003 mental health inquiry, drawing on all the information that was presented. It aims to bring out the key issues and challenges for London's mental health and mental health services. The report avoids repeating subject matter that is available in the original MHI working papers (*see* p 7), and provides recommendations.

This report is aimed at a wide range of people, including health and social care professionals, clinicians, managers, policy-makers, politicians, mental health service users and carers, people in voluntary organisations, and anyone with an interest in better understanding London's mental health. It is important to engage all these groups in debate about this report. Only by working towards a shared understanding of progress and challenges for London's mental health and mental health services will shared solutions and sustained progress come about.



2 The policy context →

The policy situation relating to mental health services in London today looks very different to that of five years ago. This chapter highlights what has changed since 1997, and looks at how these changes have impacted on mental health services, focusing on policy within the key areas of:

- modernisation
- organisational change
- patient and public involvement
- legislation and high-policy development.

2 The policy context

In many respects, the context for mental health services in London is quite different from the situation that prevailed when the 1997 King's Fund mental health inquiry was conducted. Policy shifts have not always impacted immediately, or greatly, on the experience of service users, although some of their consequences may yet be felt in the future. However, many of the changes since 1997 have been significant for those who commission or provide services – not least because of the time required to assimilate the changes and, where necessary, to act on them.

In this chapter, we give a brief overview of some of the main changes, both local and national, that have affected mental health services in London since the 1997 inquiry.

Modernisation

Since the Labour government came into power in 1997, there has been a great deal of emphasis – sometimes actual, and sometimes rhetorical – on 'modernising' public services. The term has been used loosely, to encompass many different kinds of change. The NHS, in particular, has been the focus of explicit and sustained change, much of which has been labelled 'modernisation'. There are several components to the explicit modernisation of the NHS. The main ones with relevance to mental health services are outlined briefly in the following section.

The National Service Framework for Mental Health

What has changed?

Building on the earlier White Paper entitled *Modernising Mental Health Services* (Department of Health 1998a), in September 1999 the Government launched the *National Service Framework for Mental Health* (Department of Health 1999a). Like the NHS Plan, which was launched the following year (Department of Health 2000), the emphasis of the NSF-MH was on modernity, with its subtitle *'Modern standards and service models'*.

The National Service Framework for Mental Health (known as NSF-MH) focused on the mental health needs of working age adults up to 65 and standards in five areas:

- ***Standard one*** *mental health promotion*
- ***Standards two and three*** *primary care and access to services*
- ***Standards four and five*** *effective services for people with severe mental illness*
- ***Standard six*** *caring about carers*
- ***Standard seven*** *preventing suicide.*

Department of Health (1999a, p 5)

Policy shifts have not always impacted immediately, or greatly, on the experience of service users.

The standards aimed to be realistic, challenging and measurable, and based on the best available evidence. They were intended to reduce variations in practice and deliver improvements for patients [sic], service users and their carers, and for local health and social care communities across the NHS, local authorities and the independent sector.

The NSF-MH was not seen as a 'quick fix', being essentially viewed as a ten-year programme. Some £700 million was allocated over a three-year period from 1999, in order to achieve the early targets of the NSF. In the year that the NSF-MH was published, the NHS Modernisation Fund provided almost £40 million to promote new mental health service developments for adults of working age.

The NSF-MH stated that each area should set up a local implementation team (LIT) that would bring together the key stakeholders and develop a local implementation plan (LIP). Initially, 126 LITs were established, and some have worked better than others. In London, most LITs are configured to correspond to PCT boundaries. The characteristics of a 'capable LIT' have recently been the subject of discussion and a framework is being developed to support LITs in assessing their capabilities (NIMHE 2003).

What has this meant for mental health?

The NSF-MH was extremely important as it was a clear attempt to raise the profile of mental health services and to spell out:

- national standards for mental health
- what they aimed to achieve
- how they should be developed and delivered
- how to measure performance in every part of the country.

As such, it was the first comprehensive statement that set out what was expected of health and social services in England. Although it is a framework for the whole country, it is of particular importance to London because of the extent of the variation in the nature and quality of services in London, all of which are discussed later in this report (*see* chapters 5, 6 and 9).

Despite many positive responses to the NSF-MH, there were some notes of concern. While new resources were welcomed, some felt that the resources were inadequate for the tasks ahead. There were also concerns. For example, the chief executive of Rethink believed that the emphasis in the early years was on expensive projects for people with severe and enduring mental health problems (cited in Petit-Zeman 2000). While these were seen as vital, there was also a risk that they would benefit small numbers of people at huge cost, while leaving the (greater) number of people with less severe problems in need of more help – and possibly with inadequate recognition of their needs.

Some made a more fundamental criticism about the NSF-MH: that it did not acknowledge the current debate about the medical versus social models of mental health, referring to mental health problems as 'mental illness', and failed to see users and survivors as people who have strengths as well as problems (Read 2001). One black service user saw the process of consultation on the NSF-MH as 'disempowering and damaging' (Trivedi 2001).

However, the seven standards spanned the whole spectrum of mental health needs and, significantly, put primary care at the heart of the system, as well as emphasising 24-hour access. Despite the various criticisms, for most commentators the NSF-MH still gave cause for optimism about the future of mental health services.

The NHS Plan

What has changed?

The NHS Plan (Department of Health 2000) set out to be a plan for reform and investment of health services, with sustained increases in funding for the NHS. In addition to restating a number of previously announced targets, it announced ten core NHS principles on which the modernised NHS Plan was to be based. It also introduced many new measures, and outlined how the extra money announced in the Comprehensive Spending Review was to be allocated and spent.

Many of the detailed proposals in the NHS Plan were to be applied generically across the whole NHS, or applied specifically to areas of physical health, such as treatment for cancer and heart disease. However, the NHS Plan also affirmed that modernising mental health services was to be one of the Government's core national priorities. It claimed that extra investment already committed would enable the creation by April 2001 of:

- almost 500 additional secure beds
- over 320 24-hour staffed beds
- 170 assertive outreach teams
- access to services 24 hours a day, seven days a week, for all those with complex needs.

The plan reiterated that the priority had been to ensure that people with severe and enduring mental health problems received services that were responsive to their needs. It went on to announce that by 2003/04, the Government would provide an additional annual investment of £300 million to 'fast forward' the NSF-MH. Big questions remain about exactly where mental health monies have gone, and how they have been deployed. These questions will be addressed in some detail later in this report (*see* Chapter 9).

The NHS Plan recognised that most mental health problems are managed in primary care, so it proposed a number of measures, including 1,000 new graduate primary care mental health workers, trained in brief therapy techniques of proven effectiveness, and 500 new community mental health staff. The task of these staff would be to respond to people who need immediate help. They would work with:

- GP surgeries
- primary care teams
- NHS Direct
- accident and emergency departments.

The NHS Plan has underlined the central importance of developing mental health services within a modernised NHS.

The ambitious claim was that by 2004, more than 300,000 people would receive extra help from the new primary care mental health workers, with around 500,000 benefiting from additional frontline mental health settings, thereby easing pressure on GP services. It is not clear how many of these additional staff were destined for London.

The emphasis on clinical governance gave impetus to greater transparency about services.

The NHS Plan set out further proposals for early intervention in psychosis – particularly for young people. There were also ambitious plans for extending crisis resolution and assertive outreach services. A total of 335 crisis resolution teams were to be established over a three-year period so that by 2004, anyone in contact with specialist mental health services would be able to access crisis resolution services at any time.

In addition to the 170 teams that were due to be in place by April 2001, a further 50 assertive outreach teams were to be established over a three-year period. As a result, all 20,000 people estimated to need assertive outreach services would be receiving them by 2003. As we shall see in Chapter 6, the perceptions that service users and mental health professionals have of recent progress do not entirely reflect these aspirations for additional teams and increased staffing levels.

The NHS Plan also set out investment plans to allow people to move on from high-secure hospitals to long-term secure beds, along with 400 additional community staff to provide intensive support when patients are eventually discharged. It briefly outlined plans for improved services for the 5,000 people with serious mental health problems who are in prison at any one time, though its targets were modest and somewhat vague.

In addition, the plan recognised shortcomings in mental health services for women, and pledged women-only day centres in each (then) health authority. It also set out improved support and respite services for carers.

Finally, the plan announced the Government's proposals for combined mental health and social care trusts, and for reforming the Mental Health Act 1993. The focus on reforming the Mental Health Act was to be on managing risk and providing better health outcomes for patients. At the time of the NHS Plan, the Government was also considering proposals for those people with severe personality disorders who present a high risk to the public. This theme of being caught between, on one hand, the reality of high levels of need for services in primary care and in the community, and on the other, a growing concern about risk and potential danger on the other, is a dilemma that is encountered and discussed further throughout this report.

What has this meant for mental health?

The NHS Plan has underlined the central importance of developing mental health services within a modernised NHS. However, concerns remain about how best to balance the various priorities within the field.

Health and social care partnerships

The NHS Plan emphasised the importance of integrated care to provide people with better 'access to seamless care which is tailored to meet their particular needs' (Department of Health 2000, p 70). This built on the Health Act 1999, which introduced the use of:

- **pooled budgets** so local health and social services could put money into a single dedicated budget

- **lead commissioning** enabling either the local authority or the PCT to take a lead in commissioning services on behalf of both bodies
- **integrated providers** in which local authorities and NHS bodies could merge their services to deliver a one-stop package of care.

These 'flexibilities' were intended to remove many of the financial and organisational barriers to effective working.

What has changed?

The Health and Social Care Act 2001 (HM Government 2001) placed a duty of partnership on local authorities and health bodies. In addition, the Act made the establishment of care trusts possible. The Government has seen these developments as offering a pragmatic way forward to modernise health and social care, and to integrate services that are focused on the needs of service users.

What has this meant for mental health?

In Camden and Islington, a care trust has been formed. Elsewhere, other forms of partnership have developed.

The development of clinical governance

What has changed?

The period between the two King's Fund mental health inquiries saw a flurry of policy, and subsequent initiatives and activities, designed to improve the quality of health and social care services in general, including services for people with mental health problems. The concept of clinical governance gained currency. Clinical governance has been variously defined, but one of the most-quoted definitions is as follows:

> *Clinical governance is a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.*
>
> Department of Health (1998b, p 33)

The Commission for Health Improvement (CHI) was established under the 1999 Health Act and its associated regulations. It was set up as a non-departmental body covering England and Wales, with statutory powers, but independent from government. It was intended to help improve the quality of patient care, by helping the NHS address unacceptable variations and ensuring a consistently high standard of patient care. It aimed to put the patient experience at the centre of its work.

By early 2003, CHI had completed 20 clinical governance reviews in mental health trusts, eight of which were in London. In March 2003, it produced a report (Commission for Health Improvement 2003a) highlighting a number of strengths, weaknesses and good practices from the trusts it had reviewed. This overview may

help achieve some consistency in mental health services and to learn lessons across the board.

However, CHI is destined for a short life. In April 2002, the Secretary of Health announced plans to establish two new independent inspectorates to:

- make those responsible for the commissioning and delivery of health and social services more accountable
- demonstrate how the additional money being invested in these services is being spent and enable those commissioning and delivering care to judge how their performance is improving as a result
- streamline inspection arrangements for health and social care.

In 2004, CHI will mutate into the Commission for Healthcare Audit and Inspection (CHAI) and will encompass:

- all the current and proposed work of CHI
- the Mental Health Act Commission (MHAC)
- the national NHS value-for-money work of the Audit Commission
- the independent healthcare work of the National Care Standards Commission (NCSC).

Similar changes are afoot in social care, where the new Commission for Social Care Inspection (CSCI) brings together the work undertaken by:

- the Social Services Inspectorate (SSI)
- the SSI/Audit Commission joint review team
- the social care functions of the short-lived NCSC.

What has this meant for mental health?

The emphasis on clinical governance gave impetus to greater transparency about services, and to the possibility of comparing the quality of services in different places. This may have been particularly important in increasing the level of concern about access to, and the quality of, mental health services – in which considerable inequalities persist, even within London.

Although there has been turbulence in the structures to support clinical governance and quality improvement, the commitment in principle to developing these structures has probably had some impact on mental health services (as in other services) in reinforcing the importance of delivering high-quality services within a national framework.

The emphasis on clinical governance gave impetus to greater transparency about services, and to the possibility of comparing the quality of services in different places.

Organisational change

This section looks at how some of the changes that have been seen in health organisations and local government, and the period since the first King's Fund mental health inquiry has been one of almost constant change in these areas. Some of these have relevance to the whole country, and some (such as the establishment of the Greater London Authority) are relevant mainly to London. All the changes have direct relevance to mental health.

The Greater London Authority and the Mayor

What has changed?

In 1999, the Greater London Authority Act created a mayor for London and the London Assembly, which constitute a new form of strategic, city-wide government for London. The mayor and the assembly assumed their main responsibilities on 3 July 2000.

This was a very important step for London, which had been without a city-wide government since the abolition of the Greater London Council (GLC) in 1986. The GLC, created in 1965, was preceded by the London County Council, established in 1887, covering the inner part of London, before the later growth of the suburbs. So the period between 1986 and 1999 represented an unfortunate hiatus in the continuity of London government, and temporarily gave London the dubious distinction of being a major capital city without a city-wide government.

Health is one of the main responsibilities of the GLA, along with issues such as transport, policing, culture, environment, and fire and emergency planning. The GLA is neither a commissioner nor a provider of London's health services, but it does have an important duty to promote the health of Londoners, and to take into account the effects of its policies on the health of Londoners.

The GLA has commissioned a number of publications that are relevant to mental health in London, including one on housing and support for Londoners with mental health problems (GLA 2003). In order to be effective on health issues – as on other matters, the mayor and the assembly need to work in partnership with a range of individuals and organisations.

The mayor appointed a senior public health doctor (the London director of public health) to his advisory cabinet to advise on health issues. In October 2000, he also set up the independent London Health Commission, to drive forward health improvement in priority areas across London, and to advise on health impacts of strategy proposals.

The London Health Commission's key role is to adopt and drive the development of the London Health Strategy (published in March 2000), and to make sure health is integrated across the range of London strategies – in particular, the GLA strategies.

The health strategy takes a broad view of health and its determinants. Its four key priority areas are:

- regeneration
- inequalities
- black and minority ethnic health
- transport.

What has this meant for mental health?

All of these areas are directly relevant to the mental health of Londoners. In addition to the strategy priorities, the commission will also take forward priorities identified by the mayor – one of which is mental health. While it is too early to

assess the impact of the commission and its work on health generally – or mental health in particular – there are clear opportunities to work on London-wide mental health issues in a co-ordinated way.

Local government – overview and scrutiny functions

What has changed?

The Local Government Act 2000 required all local councils to introduce at least one overview and scrutiny committee (OSC) to hold to account those responsible for the council's decision, and to review its work. The Act also gave those committees wider powers to make reports or recommendations on matters that affected the area or inhabitants of the area served by the council – so, in effect, councils have had powers to look at matters including the local health economy for some time.

These powers were strengthened in respect of health scrutiny by the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (Department of Health 2002b). These regulations were laid under powers conferred by the Health and Social Care Act 2001. They state:

> *An overview and scrutiny committee may review and scrutinise any matter relating to the planning, provision and operation of health services in the area of its local authority.*
>
> Department of Health (2002b, p 1)

OSCs were also given powers to make reports and recommendations to local NHS bodies on any matters that they reviewed or scrutinised. Local NHS bodies were required to provide information about the planning, provision and operation of health services within the council's area, as reasonably required by the committee, in order to discharge its functions. An OSC may also require an officer of a local NHS body to attend the committee and answer questions.

OSCs are at an early stage of development, and vary in how they go about their business. However, as committees find their feet, one would expect that the role of local government in health matters will develop apace.

What has this meant for mental health?

It is not yet possible to assess in detail the extent to which OSCs are actively scrutinising mental health services, but there are many examples in OSC minutes of local councils trying to grapple with mental health issues and services. OSCs still have some way to go in developing their skills. As the Audit Commission (2001) notes, the new roles present significant challenges for local authorities – particularly those that have little prior experience of scrutiny, or poor relationships with local NHS bodies.

The Audit Commission points out:

- *Scrutiny requires elected members to develop new skills and take a more active, investigatory role*

It has become a truism to say that the NHS has been undergoing a period of constant organisational change.

- *If they are to have influence, overview and scrutiny committees will need to engage constructively with other local agencies*
- *Care is needed to avoid duplicating existing mechanisms for patient and public involvement in health, or NHS performance management*
- *Elected members need to develop a basic understanding of issues affecting the local health economy, but their role is not to become health 'experts'.*

Audit Commission (2001, p 1)

Reorganisation in the NHS

It has become a truism to say that the NHS has been undergoing a period of constant organisational change. Some would argue that these changes lay the foundation of fundamental and essential reform, while others contend that constant changes have been so time consuming and distracting to those involved that they have, up to now, stood in the way of the real changes that would benefit service users and staff alike.

Whatever one's view of the value or otherwise of the ongoing flux in the NHS, it is incontrovertible that the NHS has experienced major structural changes at all levels since the last King's Fund mental health inquiry. This may have impacted particularly on mental health trusts. The Audit Commission recently reported that mental health trusts show the highest number of weaknesses in both performance and capacity across the board, while PCTs stand out as the weakest in management capacity (Audit Commission 2003). It attributes this to the fact that mental health trusts and PCTs have been subject to more recent reorganisation than acute, specialist acute and ambulance trusts, and may take time to settle down.

The Department of Health and the health and social care directorates

What has changed?

In central government, there have been significant changes in the Department of Health that may lead to a lack of focus on London and its particular needs. Changes were mooted in *Shifting the Balance of Power* (Department of Health 2001a), which emphasised that the Department of Health needed to change how it worked and change its relationship with the NHS, by stepping back from operational issues, and doing the things that only the Department of Health could do.

Shifting the Balance of Power outlined the Department of Health's role as:

- ***Secure management and accountability of the overall system**: the Department is responsible for the overall health and social care system, setting direction and securing resources, relationships with other Government Departments, helping the services integrate and modernise and ensuring delivery*
- ***Develop policy and project managing major changes** such as the National Service Frameworks*

Primary care organisations have been through several waves of change in the past few years.

- *Allow the space for local initiative and responsibility but within a **regulatory and inspection framework**, the latter increasingly happening at arms length*
- *Intervention where necessary.*

Department of Health (2001a, p 13)

Within the Department of Health, four directors of health and social care were to be responsible for working directly with the NHS and performance managing strategic health authorities. The whole of London was (briefly) covered by a single DHSC. Its functions included overseeing and developing health and social care in London, making sure local health and social care communities were developed in an integrated way to deliver modernised services.

However, in February 2003 – just nine months after their inception – it was announced that the four DHSCs were to be abolished as part of a radical overhaul of the Department of Health. This reorganisation rested on the assumption that more work could be devolved to the developing strategic health authorities. By April 2004, the Department of Health was reorganised into five functions:

- a chief executive's office, co-ordinating policy and strategy
- performance management (taking over the work of the DHSCs)
- public health
- corporate management and development
- the Modernisation Agency.

What has this meant for mental health?

The significant aspect of all this change is that once again, after a short period during which London had one single body looking at health and social care across the capital, there is now no pan-London focus. With the demise of the London DHSC, the five strategic health authorities in London have joined together to form the 'London Cabinet', to ensure there is a co-ordinated NHS approach to key London issues (London NHS Confederation 2003b).

Lead responsibility for specific issues in London is spread across the five strategic health authorities, but as yet there is little evidence that this is an effective way to ensure an integrated perspective of needs and services in London.

In a context in which standards of mental health services vary, and fragmentation is rife, this is a situation in need of an urgent remedy (*see* Chapter 11), and the ability to respond to some of the challenges for London's mental health and mental health services needs to be strengthened.

Health authorities

What has changed?

England's 95 health authorities have been replaced by fewer strategic health authorities. There are now 28 strategic health authorities in England, and London's 14 health authorities merged to become five strategic health authorities. The role of strategic health authorities is to agree an annual delivery plan with the Department of Health, and to ensure its delivery by the local health community.

How does this affect mental health?

As well as creating a strategic framework with stakeholders, strategic health authorities hold PCTs and NHS trusts to account, through performance agreements. Where necessary, they can broker strategic solutions to resolve conflicts and make sure objectives are delivered. They also play important roles relating to capital investment, information management and workforce development. Arguably, these functions do not offer a framework for the five London strategic health authorities to provide a focus for appropriate and effective development of mental health care across London.

Primary care

What has changed?

Primary care organisations have been through several waves of change in the past few years. These changes are set out clearly in *Developing Primary Care in London* (Florin *et al* 1999). Some of them took place before 1997, when the last mental health inquiry was carried out, as GP fundholding was introduced by the NHS and Community Care Act 1990.

Uptake in fundholding was slower in London than elsewhere in the country. Then, in 1995/96, multifunds began to form. These were groups of GP fundholders who joined together in independent organisations to administer and manage their fundholding services as a group. Unlike single fundholding practices, multifunds were more common in less affluent areas. In some ways, multifunds provided a path towards primary care groups (PCGs).

Next came total purchasing pilots (TPPs), made up of single-practice fundholders or groups of fundholding practices. There were seven TPPs in London, although the majority were found in rural, affluent areas. GP commissioning groups came next, in April 1998, as groups of largely non-fundholding practices. They aimed to exert pressure on health authorities to make purchasing more sensitive to local variations in need and patients' views, as mediated through GPs. London was the single region with the greatest number of GP commissioning pilots.

PCGs grew out of all these antecedents. They came into being in 1999, and developed through a series of levels into primary care trusts (PCTs) – initially on a voluntary basis, and ultimately, by strong encouragement that amounted to government edict, so that by 2003 PCTs were the norm for primary care organisations throughout England. PCTs are now the cornerstone of the local NHS, responsible for improving health, commissioning services, and building new partnerships with other PCTs, NHS trusts and local communities. PCTs are currently in place across the whole country, although individual levels of experience and expertise vary.

What has this meant for mental health?

Some of the changes had a more immediate impact in London than others, as some of the various forms of primary care organisational development were welcomed more by affluent areas outside the largest cities, while others took root

NHS trusts need to review their systems and approaches, to provide greater devolution to clinical teams and increase the involvement of patients and the public.

more readily in urban areas. The fine details are less important here than the general pattern of constant evolutionary (and sometimes, revolutionary) change. The issue of whether this plethora of primary care developments has advanced positive changes in London's mental health services is addressed in Chapter 5.

NHS trusts

What has changed?

The statutory functions of NHS trusts have not been changed by *Shifting the Balance of Power*. However, under the new system, they are performance-managed by the strategic health authorities, and they are required to work ever more closely with PCTs and other local partners to:

- redesign local services around the needs and convenience of patients
- develop strategies to reduce health inequalities and improve the health of the whole population
- deliver safe, high quality services and have effective clinical governance arrangements to fulfil their statutory duty of quality
- deliver national priorities
- address local priorities, as identified through local surveys of patient experience and the local modernisation reviews.

They also need to review their systems and approaches, to provide greater devolution to clinical teams and increase the involvement of patients and the public.

The configuration of mental health trusts in London has changed. There are now ten mental health trusts in London (or 11, if the Tavistock and Portman NHS Trust, with its range of specialist services, is included), compared to the 28 trusts that were reported as delivering acute mental health services in London in 1996 (Johnson *et al* 1997, p 221). The chief executives of these trusts meet regularly to discuss developments in London's mental health services, and to respond to national initiatives.

The current list in 2003 is as follows:

- Barnet, Enfield and Haringey Mental Health Trust
- Camden and Islington Mental Health and Social Care Trust
- Central and North West London Mental Health Trust
- East London and the City Mental Health Trust
- Hillingdon Hospital NHS Trust
- North East London Mental Health Trust
- Oxleas NHS Trust
- South London and Maudsley NHS Trust
- South West London and St George's Mental Health Trust
- West London Mental Health Trust.

What has this meant for mental health?

These mental health trusts are now larger and more powerful than the trusts that were responsible for mental health in 1997. All have to work with several local authorities and PCTs.

NHS foundation trusts

What has changed?

A further change on the horizon for NHS trusts is the introduction of NHS foundation trusts. At the time of the 2003 King's Fund mental health inquiry, this controversial development was under active discussion inside and outside Parliament, but the reality of foundation trusts had not yet come into being. The Government commends the establishment of NHS foundation trusts as a way of decentralising and freeing the best NHS trusts from Whitehall control.

Opponents of foundation trusts have concerns about the potential to exacerbate inequalities in service provision. They also fear that the freedoms that foundation trusts will enjoy may enable them to offer better pay and conditions at the expense of non-foundation trusts.

What has this meant for mental health?

The Government sees foundation trusts as a way of increasing control by local people, although it is not entirely clear how that might play out for mental health services, given the prejudices, fears and concerns that often prevail in local communities about having mental health facilities in their locality.

Virtually the entire debate has centred on acute services, but the potential impact of foundation trust status on mental health services is considerable. It seems likely that foundation status will gradually become widespread – and probably universal – within the NHS, just as trust status itself spread throughout the system in irresistible waves. All the potential risks and benefits that apply to foundation trusts generally apply also to mental health foundation trusts.

However, there are a few additional issues that might have particular significance in the context of mental health services. For example, since recruitment and retention is a particular challenge for mental health services, and it can be difficult to attract people into the mental health professions, competition within the mental health labour market may be tougher than in other parts of the NHS.

There are also concerns that foundation status may make trusts inclined to innovate in isolation, rather than in partnership with other parts of the NHS and related services. Yet mental health trusts rely on effective partnerships – especially with local government and PCTs – to a greater extent than acute NHS trusts. Given the growing size of the average mental health trust, foundation status may make them even more powerful than their partners in delivering local services, and thus make for some very unequal partnerships.

The effects of ongoing change

To sum up, the history of relentless change in the NHS and beyond – with more radical change yet to come – has been a major contextual factor for London's mental health services. Individual assessments will vary in the extent to which changes have enabled services to improve in the long term. In the medium and short term, it seems highly likely that people with responsibilities for

commissioning and providing services have had to divert a great deal of energy into managing change.

At the same time, reorganisations have caused insecurities about future employment, and many people have changed their jobs and their job titles with alarming frequency. Whether or not the pain has been worthwhile, the consequences for mental health services within the period between the two King's Fund mental health inquiries is almost certainly considerable. The challenge of consolidation and forward momentum lies ahead.

Involving patients and the public

To understand how patient and public involvement (PPI) has developed, one needs to take into account the long history of the mental health service user/survivor movement. Indeed, many of the aspects of user involvement that are now finding their way into usual practice in health and social care organisations were successfully pioneered by mental health service users:

> *The trust will phone and ask how they can find out what people think of this or that, and I say 'Well, go out and ask them.'*
>
> *... people do want to include us but they haven't got an idea of when to ask.*
>
> Participants, King's Fund discussion groups

The history of the mental health service user movement is concisely described in a recent publication (Wallcraft and Bryant 2003). Another Sainsbury Centre publication describes and analyses the mental health service user/survivor movement in England at the present time, and makes policy recommendations to improve the current situation (Wallcraft *et al* 2003). These are important resources for building on what has gone before, and taking forward the implementation of new policies on involving people in their own care, and in the planning, delivery and monitoring of services.

In the 2003 King's Fund Mental Health Inquiry discussion groups, service users spoke of the significant growth of service-user involvement over the past few years. The nature of this involvement included participating in:

- appointing staff
- staff training initiatives
- quality-improvement groups
- service-development groups (for example, working on the development of new inpatient wards)
- training for the local police, particularly in relation to using section 136 powers
- offering support to others.

In the discussions, many staff (including one trust chief executive) said they had often worked hard to push these initiatives forward.

Much remains to be done to enable mental health service users to have an effective voice. Work is also needed to better involve families and carers of people with mental health problems. In MHI Working Paper 5, Keating *et al* (2003) point out that the needs of families and carers are often conflated with those of service users. It must be acknowledged that their needs are different (and often competing), and that they must be addressed separately, rather than under the

Much remains to be done to enable mental health service users to have an effective voice.

rubric of 'service-user involvement'. They add that black carers face significant challenges, due to stereotypical views about caring in their communities. For example, stereotypes relating to extended families and notions that 'they look after their own' can serve to hinder effective service interventions and support for carers.

What has changed since 1997?

Since the previous King's Fund mental health inquiry, there have been major changes to the structures for patient and public involvement. This section offers a brief summary of the main proposals, and actual changes, to patient and public involvement structures, as a backdrop to better understand the realties of change.

Detailed proposals for new PPI structures emerged gradually after the abolition of community health councils (CHCs) was announced in the NHS Plan – almost as an aside. In spite of a vigorous campaign by MPs, the Association of Community Health Councils for England and Wales (ACHCEW), CHCs and the public, the abolition of CHCs was agreed. It was originally due to take effect on 1 September 2003, and was later postponed, at the 11th hour, to 1 December 2003, when patients' forums (now to be known as 'patient and public involvement forums') would supposedly be in place across the country.

The Government's determination to abolish CHCs was presented in the context of the modernisation of the NHS. The new proposals were also designed to respond to issues about the need for wider user involvement, raised in the course of the Bristol Royal Infirmary Public Inquiry (2001), which looked at the management of care of children receiving complex heart surgery at the Bristol Royal Infirmary. Most people would concede that while CHCs made a major contribution over a long period, some reform was necessary, However, many people would also argue that by abolishing CHCs completely, the baby was thrown out with the bath water, and that the accumulated expertise of CHC members and staff will now be lost.

The new PPI structures are now as follows:

- **the Independent Complaints Advocacy Service (ICAS)** where people can get help in pursuing formal complaints
- **the Patient Advice and Liaison Service (PALS)** providing on-the-spot help, and information about ICAS
- **a patient and public involvement forum** in every NHS trust and PCT, to influence the day-to-day management of health services by the trust, and monitor the effectiveness of PALS and ICAS in their area
- **the Commission for Patient and Public Involvement in Health** set up as an independent non-departmental body by the Department of Health, with a remit to ensure that the public is supported in decision-making about health and health services
- **local network providers** not-for-profit organisations contracted to support patient and public involvement forums.

Opinion is still divided on the extent to which these changes will enable the greater involvement of patients and the public. Many fear that new structures will turn out to be insupportably expensive and bureaucratic, and that important expertise will be lost in the transition from old structures to new.

New duty to consult

Section 11 of the Health and Social Care Act 2001 places a statutory duty on NHS trusts, PCTs and strategic health authorities to make arrangements to involve and consult patients and the public in service planning and operation, and in developing proposals for changes. This is a new statutory duty, which requires them to consult and involve patients and the public in ongoing service planning and development – not simply when a major change is proposed. The duty also extends to consulting on decisions about general service delivery – not only on major changes. The duty to involve and consult came into force on 1 January 2003.

What has this meant for mental health?

In rhetorical terms, it seems that the battle for greater patient and public involvement in mental health services has been won. Ministers compete to promote patient and public involvement harder than their colleagues, and local NHS managers all speak with one voice to praise the principles of user involvement in a way that would have been unthinkable a decade ago. However, whether the rhetoric is matched by reality is another matter.

Legislation and high-level policy developments

It is impossible to do justice in a short section to the wide range of legislation and policy developments that are relevant to the changing context of mental health services in London. However, some of the recent developments are so central to current thinking on mental health service development that they must be acknowledged here.

Disability Discrimination Act (DDA) 1995

What has changed?

The largest part of this Act came into force in December 1996, so it was already in place at the time of the 1997 mental health inquiry. However, its effects will have been felt mostly in the ensuing period. The DDA makes it unlawful to discriminate against those with a disability when providing services, and for most employers when providing employment.

What has this meant for mental health?

A human rights perspective on mental health policy and practice is an important development.

The definition of 'disability' within the Act includes 'any impairment resulting from or consisting of a mental illness' (HM Government 1995, p 56), but only if it is 'clinically well recognised'. For all practical purposes, this includes major mental health diagnoses, and common conditions such as depression and anxiety, although the need to have a diagnostic label in order to be covered by the Act is not without problems. The Act applies only to impairments that have lasted for at least 12 months or are likely to do so, or are likely to last for the person's life or be recurrent. These stipulations exclude many people with mental health problems.

The Human Rights Act 1998

What has changed?

In October 2000, the European Convention of Human Rights was incorporated into UK law, when the Human Rights Act 1998 was implemented. The Act requires public authorities and their employees to act compatibly with convention rights, and failure to do so may lead to a legal claim.

What has this meant for mental health?

A number of articles of the convention are particularly relevant to mental health service users. A greater awareness of these articles, and a relatively small number of legal claims, is leading public authorities (including health and social care organisations) to look carefully at their practices in order to ensure that they are not violating convention rights.

Many of the issues that concern mental health service users will not normally be open to challenge under the Human Rights Act. For example, as Mind points out, the principle of medication without consent is lawful under the convention (Mind 2000). However, the articles that are most significant for mental health users are as follows:

- **Article 2** right to life
- **Article 3** protection against torture
- **Article 5** deprivation of liberty
- **Article 6** a fair hearing
- **Article 8** private and family life
- **Article 9** freedom of thought, conscience and religion
- **Article 10** freedom of expression
- **Article 14** non-discrimination.

Each of these rights is a qualified right, which is open to interpretation and contains exclusions. Nevertheless, a human rights perspective on mental health policy and practice is an important development.

The Stephen Lawrence Inquiry

What has changed?

In February 1999, the Stephen Lawrence Inquiry Report was published (Macpherson 1999). This report looked at matters arising from the death of Stephen Lawrence, a black teenager from south London, to identify lessons learned from the investigation and prosecution of racially motivated crimes. Although the report had no direct remit to focus on racism and mental health, its impact has been widely felt on all public services, including all health and social care services, because of its definitions of racism and institutional racism:

> *'Racism' in general terms consists of conduct or words or practices which advantage or disadvantage people because of their colour, culture or ethnic origin. In its more subtle form it is as damaging as in its overt form.*
>
> Macpherson (1999, section 6.4)

> *'Institutional racism' consists of the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantage minority ethnic people.*
>
> Macpherson (1999, section 6.34)

What has this meant for mental health?

The debates that ensued about institutional racism reached most parts of health and social care services and, together with work done following the Race Relations Amendment Act 2000 (*see* below), it might be expected that significant changes in mental health services would be apparent since the first King's Fund mental health inquiry. The extent to which that is so is examined later in this report (*see* Chapter 6).

The Race Relations (Amendment) Act 2000

What has changed?

The Race Relations (Amendment) Act 2000 amended the Race Relations Act 1976. The 1976 Act made it unlawful to discriminate on racial grounds in relation to employment, training and education, the provision of goods, facilities and services, and certain other specified activities.

Although the 1976 Act applied to race discrimination by public authorities, it did not cover all the functions of the public authorities. The Commission for Racial Equality (CRE), in its *Third Review of the 1976 Act* (CRE 1998), proposed that the Act should be extended to all public services.

The main purposes of the 2000 Act are to:

- extend further the 1976 Act in relation to public authorities, outlawing race discrimination in functions not previously covered
- place a duty on specified public authorities to work towards the elimination of unlawful discrimination and promote equality of opportunity and good relations between persons of different racial groups
- make chief officers of police vicariously liable for acts of race discrimination by police officers
- amend the exemption under the 1976 Act for acts done for the purposes of safeguarding national security.

The general duty on public authorities to eliminate race discrimination, promote equality of opportunity and promote good race relations between people of different racial groups is supported by a series of specific duties, applicable to both employment and service delivery. By ensuring that they are complying with the specific duties, public authorities will ensure that they are delivering on the general duty outlined in the Act.

By 31 May 2002, each public authority was required to produce a 'race equality scheme', setting out how it planned to meet the requirements outlined in the

Of the many policy changes in housing and social care for people with mental health problems, one of the most significant is Supporting People.

specific duties. These race equality schemes are intended to help organisations clarify their goals for equality, and chart an action plan for achieving them.

What has this meant for mental health?

Given the high level of concern about racism and discrimination within mental health services, the length of time for which it has existed, and the fact that it persists today, the scheme is potentially an important vehicle for positive change in mental health services.

Supporting People

What has changed?

Of the many policy changes in housing and social care for people with mental health problems, one of the most significant is the recently launched programme Supporting People.

What has this meant for mental health?

Supporting People makes local authorities responsible for funding, planning and commissioning all housing-related support services, in partnership with service users and support agencies. This integrated approach offers vulnerable people the opportunity to improve the quality of their lives by providing a stable environment that enables greater independence. The potential impact of this programme is very great. (For further discussion of Supporting People *see* Chapter 7 on housing.)

Reforming the Mental Health Act 1983

What has changed?

As promised in the White Paper entitled Reforming the Mental Health Act (Department of Health/Home Office 2000), the Government published a new draft Mental Health Bill in June 2002. The Consultation Document on the Bill (Department of Health 2002a) stated the purpose of the Bill as follows:

- *To provide a legal structure for requiring mentally disordered people to submit to compulsory treatment, without necessarily requiring them to be detained in hospital. This will align their treatment and the legislation governing it, more closely with the structure of modern mental health services. It will enable those services to be used more flexibly both for the benefit of mentally disordered people and for the protection of others from harm.*
- *To bring the law more closely into line with modern human rights law, as defined by developing case law arising from the European Convention of Human Rights.*

Department of Health (2002a, p 6)

What has this meant for mental health?

The Bill provoked strong views from a range of quarters, including the Mental Health Alliance – a group of 60 organisations that have come together, to work on

their common concerns about the Bill. The fact that so many organisations have joined together in an alliance of service users, mental health professionals and others with such unity of purpose is an indication of the strength of feeling about the legislation.

The Mental Health Alliance noted some positive points and many more concerns about the Bill. They welcomed the fact that:

- compulsion beyond 28 days was to be authorised by a new mental health tribunal
- patients with long-term incapacity were to have new safeguards
- patients could choose their own nominated persons to act on their behalf. This would replace the 'nearest relative' provisions of the 1983 Act and apply to those subject to compulsion and to those with long-term incapacity
- there was to be a duty on ministers to provide sufficient advocates to meet 'all reasonable requirements'.

However, many organisations had serious objections to the central provisions of the Bill, which Mind described as 'unworkable and regressive' (Mind 2002, p 1). The thrust of the opposition by the Mental Health Alliance was that the Bill laid too heavy an emphasis on the use of compulsory powers.

In particular, there was a great deal of concern that the proposed 'community treatment orders', as heralded in the Bill, would both increase the use of compulsion and drive people away from treatment altogether. Many groups felt that a stronger focus on improving community and inpatient services would better alleviate the problems about which the Government was concerned.

Indeed, some groups stated that there was likely to be an increase in compulsion as a consequence of the Bill, and that if this were enacted it could actually divert resources away from the services that people with mental health problems most need. They also argued that a heavy use of compulsory powers, and the coercive nature of the functions proposed in the Bill, might deter potential new recruits to mental health professions and deter potential service users from seeking help at all.

There was great concern about the widening of the grounds for compulsory treatment, and the fact that there was no requirement to exhaust less restrictive options first, if the person was considered to be a danger to others. There was also widespread opposition to the proposed abolition of the treatability test. The new Bill proposed to make some dangerous mentally disordered people subject to the Act for the protection of others, rather than because they would personally benefit from it. This was aimed at people with personality disorders who would fall outside of the 1983 Act.

The Bill was not included in the Queen's speech in 2002, but the issues remain on the legislative agenda. The need for further consultation and a renewed look at the concerns of service users, as well as mental health professionals, has been conceded, but important philosophical and ethical differences remain to be resolved. These debates do not need to be rehearsed in detail here, as they have been – and continue to be – the subject of extensive and continuing controversy. However, the findings of the King's Fund Mental Health Inquiry beg the question:

Levels of fear and intolerance of people with mental illness have tended to increase since 1993.

has the Government's emphasis on new legislation skewed thinking towards public safety aspects of mental health, at the expense of the everyday needs of those with mental health problems who pose no threat to others?

That possibility is borne out by *Attitudes to Mental Illness*, a survey of public opinion about public attitudes towards those with mental health problems (Department of Health 2003). The survey started annually in 1993 and became three-yearly in 1997. In 2003, the survey of 1,897 adults showed that attitudes to those with mental health problems had worsened since 2000, in contrast to the period from 1993 to 2000, during which they had remained the same. The report also states 'Levels of fear and intolerance of people with mental illness have tended to increase since 1993' (Department of Health 2003, section 2.4).

Almost one-third (31 per cent) of those surveyed in 2003 agreed that 'less emphasis should be placed on protecting the public from people with mental illness', while 37 per cent disagreed, 26 per cent neither agreed nor disagreed, and 6 per cent did not know. The survey also showed that 25 per cent of those surveyed thought that people with a history of mental health problems should be excluded from public office. Paul Corry, head of policy and campaigns at Rethink, observed:

> *It is no coincidence that the worsening of public attitudes coincided with a series of government announcements making the false link between mental illness, dangerousness and the need for a new draconian mental health act.*
>
> Brindle (2003, p 4)

This downturn in public attitudes may be indicative of the continuing challenge to ensure that people with mental health problems are fully included in all aspects of social and civic activities. Although tackling social exclusion is a priority for the Government, there is a danger that people with mental health problems may themselves be socially excluded as a consequence of increasing and misplaced fears about danger that would accurately apply to relatively few people, but would blight the opportunities of many more.

Conclusions

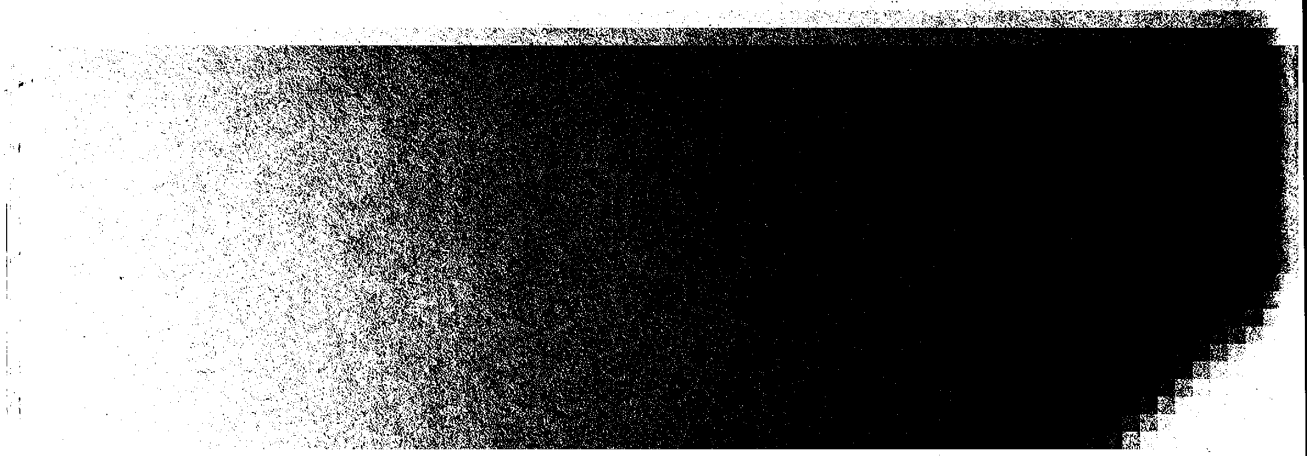
In the period between the two King's Fund mental health inquiries, there have been some major developments in mental health policy, characterised by new standards and targets being set, and new money being allocated, with the intention of modernising mental health services. This period has also been a time of legislative and policy change, with constant and widespread organisational flux affecting the NHS and local government. Some of these changes are already bringing benefits, while others are likely to bear fruit in the longer term.

Almost all of the changes to the policy context have generated controversy about their likely benefits to service users. Even where this change brings benefits, it is very likely that developments in London's mental health services have been affected by the scale and pace of change that has preoccupied so many people working in the field.

3 What is special about London's population?

This chapter looks at the characteristics of London's population, highlighting the risks to mental health and well being that make London special or different. These include:

- the age and size of the population
- the ethnic and cultural mix and the gender balance
- income, lifestyles and household composition
- homelessness
- refugees and asylum seekers
- drugs, alcohol and dual diagnosis.



3 What is special about London's population?

London differs from other cities in the UK, not just in the size of its population, but also in the diversity of its population. It has strengths and opportunities that are far greater than most other cities and it also faces challenges that are larger and more complex than those faced elsewhere. London is the size of seven cities such as Birmingham, but in many respects it is best understood as a world city, alongside New York, Paris and Tokyo. Many of London's distinctive characteristics, strengths and challenges impact on its need for mental health services, and on statutory and voluntary capacity to meet those needs. However, not all of the issues facing London's mental health services are unique, since in some respects what works well for London is also relevant to other major cities

Mental health inequalities in London are very great, and the capital faces a far greater challenge than elsewhere in dealing with high rates of homelessness and dual diagnosis of mental health with alcohol and/or substance misuse problems. At the same time, London has unique strengths, such as the benefits of a very diverse population, and unusually high opportunities for employment and leisure.

THE SIZE OF LONDON'S POPULATION

- London is one of the largest cities in the developed world in terms of its built-up area, and is the most populous city in the European Union.[1]
- London's population is of a comparable size to New York City (8 million in 2000), Paris (6.2 million in 1999) and Tokyo (8 million in 1995).[2]
- In 2001, London had 7.19 million residents, with an annual increase of about 19,000 since 1981.[1]
- By 2016, London's population will increase by 700,000 to over 8 million.[3] This increase, which is equivalent to the population of a city such as Leeds, will pose a significant challenge to mental health services for London.
- The growth in population is largely due to immigration from overseas and migration from elsewhere in the United Kingdom.
- Between 1991 and 2001, east London showed the greatest population increase, with Tower Hamlets growing by 18.2 per cent, Newham by 13 per cent, Hackney by 9.9 per cent and Barking and Dagenham by 5.7 per cent, while in west London, the population of Kensington and Chelsea has increased by 10.8 per cent.[1]

1 Virdee and Williams eds (2003)
2 World Cities Project, available at: www.nyu.edu/projects/rodwin/world_cp.htm
3 Greater London Authority (2002)

The age of London's population

London's total population figures conceal an exodus of older people from the capital, while there has been a consistently large net inflow of those aged 16–24 (Virdee and Williams eds 2003). Between 1991 and 2001, the number of Londoners aged 65 and over fell by 7.5 per cent, compared with an 11 per cent increase in those aged 20–44. Just over two-thirds (68 per cent) of London's population is under 45, compared with 60 per cent in the country as a whole, and while people of pensionable age and over make up 18 per cent of England's population, they comprise less than 15 per cent of London's population. Since most people who experience psychotic episodes present to services for the first time below the age of 45, this has an impact on the need for mental health services in London.

London has a smaller proportion of older people than other world cities, and this trend is set to continue. Population projections for proportions of people aged 60 plus indicate that by 2015 Manhattan will have 19 per cent, Paris will have 20 per cent and inner Tokyo will have 35 per cent. In contrast, by 2011 – four years earlier – only 14 per cent of London's population will be aged 60 or over (World Cities Project, available at: www.nyu.edu/projects/rodwin/world_cp.htm).

Despite this general trend, however, there are considerable differences across the city in the proportion of older people. For example, in the London boroughs of Newham, and Hammersmith and Fulham, about 11 per cent of the population are of pensionable age, compared to around 18 per cent in both Havering and Bromley.

To put the situation in perspective, however, the total number of older people in London is greater than that in Scotland, Wales or five of the other English regions (London NHS Confederation 2003a). And as older people in London have a higher prevalence of mental health problems such as depression than the national population (Livingston *et al* 1990), it can be difficult to assess the overall need for mental health services.

The household composition in the capital

London contains the highest proportion in England of people living alone, either as single people or as lone parents. Over one-third (35 per cent) of London households are made up of one person living alone, while in Westminster and Kensington and Chelsea the figure is almost half of households, and in the City of London, as much as 60 per cent. Overall, the proportion of one-person households in London is 5 per cent higher than in England and Wales as a whole. The proportion of households made up of lone parents with dependent children varies between boroughs, from less than 4 per cent in the City to nearly 12 per cent in Newham. Overall, lone parents with dependent children head 8 per cent of London households – a higher proportion than in any other region, except the north west of England (Virdee and Williams eds 2003).

People who feel isolated or lack a social-support network rely more on statutory and voluntary mental health services for support.

Both neurotic and psychotic disorders are more common in people living alone (Henderson *et al* 1998), and people who feel isolated or lack a social-support network rely more on statutory and voluntary mental health services for support.

The connection between social class and mental health has been frequently identified, both for severe mental health problems and for common mental disorders.

Married couples make up only half of London's households compared with almost 60 per cent in England as a whole. Given that mental health problems are least prevalent in married couples (Henderson *et al* 1998), this again suggests that London will have proportionally more mental health problems than the English average.

London has significant numbers of lesbians, gay men, bisexuals and transgender people. The stigma, social exclusion and prejudices that they frequently face can affect their mental health and well being (Paul *et al* 2002). Echoes of the recent past, when some mental health professionals viewed homosexuality as a 'mental illness' may also contribute to the ways in which lesbians, gay men and bisexuals have been treated within mental health services (McFarlane 1998). In MHI Working Paper 1, Heer and Woodhead (2002) state that homophobic bullying in schools is common, and that these groups routinely experience harassment and violence. For some gay men, being HIV positive has a strong impact on their mental health and well being, and carers of people with HIV/AIDS often experience long-term stress (Golding 1996).

London's gender balance

In terms of the link between gender and mental health, women experience roughly double the prevalence of common mental disorders among men. The rates of psychosis, however, are similar for men and women (Henderson *et al* 1998). Recent figures show that as with most other parts of the UK, London has a higher proportion of females than males among its resident population, at 52 per cent (Virdee and Williams eds 2003).

The social class and income of Londoners

The connection between social class and mental health has been frequently identified, both for severe mental health problems, such as schizophrenia (Henderson *et al* 1998) and for common mental disorders, such as depression and anxiety (Lewis *et al* 1998, Weich and Lewis 1998). For example, consultation rates in primary care for psychiatric disorders are 70 per cent higher for patients in Social Class 5 than for those in Social Class 1 (Shah *et al* 2001). (For details of social class categorisations used, see the Glossary, pp viii–xxiii.)

Whether this gradient is created by social drift or social factors has long been debated. Recent support for the latter hypothesis comes from case-control and longitudinal studies, which have indicated that socio-economic deprivation at birth or in early childhood is strongly associated with increased risk of developing psychoses and some neuroses later in life (Harrison *et al* 2001, Ritsher *et al* 2001, Fan and Eaton 2001).

So, based on this, expected prevalence of mental health problems would be high in London, where the incomes of the wealthiest 20 per cent are more than seven times higher than those of the bottom 20 per cent, while the difference in the rest of the country is less than five times (Greater London Authority 2002). London's inner city contains some of the most deprived wards in the UK on almost any of the commonly used scales. The Government's most recent Index of Local Deprivation (Office of the Deputy Prime Minister 2000a) assesses six 'domains':

- income
- employment
- geographical access to services (including to a GP)
- education
- skills and training
- health deprivation and disability
- housing.

It finds that Tower Hamlets, Hackney and Newham are the most deprived local authorities in England, and five London boroughs are in the ten most deprived districts in England.

This link between mental health and deprivation is clearly illustrated in the hospital admission rates for mental health problems, by borough: in 2000/01, there were 819 admissions per 100,000 people in the relatively poor borough of Hackney, whereas in the comparatively affluent borough of Kensington and Chelsea the figure was 199 (Department of Health 2001b).

However, for at least some psychiatric conditions, the picture in London may be more complicated. Those with high incomes in London experience common mental disorders more than high earners in other parts of the country where income inequalities are less pronounced. This may be due to factors particular to the capital, such as its high cost of living and house prices, higher crime rates, and its prestigious jobs in the financial and business sectors, where competition is fierce and pressure to succeed is great (Weich *et al* 2001).

On the other hand, London's low earners have fewer common mental disorders than those in other parts of the country, and the reasons for this are unclear. It should be stated, however, that although Weich *et al*'s analysis was published in 2001, the information behind it was collected in 1991, and needs corroborating. If it is verified, then it is a reminder that even in more affluent areas, there is a need for appropriate primary and secondary mental health care and counselling services.

This does not detract in any way from the need to tackle poverty, nor from the correlation between mental health problems and low income or social class. Despite recent changes to benefits and tax, income inequality rose in the UK between 1996/97 and 2000/01, and the numbers of children living in poverty fell by only 11 per cent, from 4.4 million in 1996/97 to 3.9 million in 2000/01 (Brewer *et al* 2002).

How is London affected by homelessness?

Efforts by the Government's Rough Sleepers' Unit have decreased the numbers of people sleeping rough in London by over 50 per cent, from 621 in 1998 to 264 in 2001 (Homeless Link 2002). However, by 2001/02 London still contained more than 31,000 people accepted as being homeless and in priority need of accommodation – over one-quarter of England's total homeless population. In Newham, for every 1,000 households 15 people are deemed homeless and in need of priority housing, while in Haringey the figure is 24 per 1,000.

As many as 30–50 per cent of the homeless population have a severe mental health problem.

London's boroughs house 46,890 households in bed-and-breakfast lodgings, hostels and other accommodation – 59 per cent of the total number of households in council accommodation in England (Office of the Deputy Prime Minister 2003).

As many as 30–50 per cent of the homeless population have a severe mental health problem (Bird 1999), with the most prevalent mental disorders including depression, affective disorders and schizophrenia (Martens 2001). In one review, the prevalence of depression in homeless people was found to be at 33 per cent, more than twice the figure of 15 per cent in the housed population (Sims and Victor 1999). In a systematic review of literature on homeless people with a diagnosis of schizophrenia, the prevalence rate was 4–16 per cent, with a weighted average of 11 per cent, and higher rates found in younger people, women and the long-term homeless (Folsom and Jeste 2002). Just under half of those diagnosed with schizophrenia were not receiving treatment.

What is London's ethnic and cultural mix?

London has always enjoyed a rich ethnic diversity in its population. Almost one-third of its population is of black or minority ethnic origin, and London's children speak more than 300 languages. The makeup of London's population is forecast to continue to change (Greater London Authority 2002).

The two largest non-white ethnic groups in London continue to be South Asians and black African-Caribbeans. Almost two-thirds of England's black population live in London. These groups experience high levels of unemployment and homelessness.

TABLE 1: VARIATION IN SOCIO-ECONOMIC FACTORS AND PREVALENCE OF MENTAL HEALTH PROBLEMS, BY ETHNIC GROUP

Ethnic group	Percentage of London's 2001 population[1]	Unemployment (% of total ethnic group population) (2000/01)[2]	Homeless households per 1000 ethnic group households[2]	Prevalence of any neurotic disorder in the past week (%)[3]	Estimated annual prevalence of psychosis (%)[3]
White	72.5	5.1	1.8	15.8	0.8
Black Caribbean	4.8	15.7	7.8	17.3	1.6
Black African	4.3	18.9			
Black other	1.8	16.8			
Indian	6.1	5.9	2.8	18.1	1.1
Pakistani	2.0	14.2		19.6	1.3
Bangladeshi	1.9	24.1		12.6	0.6
Mixed/other	6.5	11.4–14.9			

Sources
1 Greater London Authority (2002)
2 London Health Observatory (2002)
3 Sproston and Nazroo (2002)

The EMPIRIC study (Sproston and Nazroo 2002) found that white non-British groups, such as the Irish, make up 5 per cent of the UK population – and significantly more of the population in some parts of London. Irish men have higher prevalence of common mental disorders – especially anxiety – than other ethnic groups.

Men from South Asian countries do not have significantly different rates of common mental disorders or psychoses to those of white men, although South Asian 'migrants' (those who arrived in the United Kingdom after the age of ten) have lower rates than 'non-migrants'.

However, the basic category 'South Asian' conceals many important differences between Indian, Pakistani and Bangladeshi groups, in health and standards of living. For example, Bangladeshi non-migrants had lower rates of common mental disorders than Bangladeshi migrants (8 per cent and 14 per cent respectively), while in Indian men, the trend is reversed. Young women born in India and East Africa have higher rates of suicide than the general population (Nazroo 1997), while Pakistani women have higher rates, and Bangladeshi women lower rates, of common mental disorders (26 per cent and 12 per cent respectively) than white women, at 9 per cent (Sproston and Nazroo 2002).

The study indicates that Bangladeshi women tend to live in areas with high levels of socio-economic deprivation. This runs counter to the idea of deprivation being associated with mental health problems. However, it may be that the markers of deprivation used were not appropriate to Bangladeshi culture, or that deprivation is dealt with better in some communities – by, for example, increased social support networks. Equally, in some communities, mental health problems may go undiagnosed and untreated.

The EMPIRIC study found that for black Caribbean and white people, rates of psychosis are related to socio-economic position, with the poorer people, and those living in inner cities, having increased risk. However, neither this study nor *Ethnicity and Mental Health: Findings from a national community survey* (Nazroo 1997) found any statistically significant increase in the rate of psychosis in black African or Caribbean men or women, compared with the indigenous white population. Despite this, the rate of first contact with treatment services for black African-Caribbeans with a first diagnosis of schizophrenia appears three-to-five times greater than that of the white population alone (Henderson *et al* 1998).

There is also consistent evidence that the rate of compulsory detention under the Mental Health Act 1983 is significantly higher for black people than that of the general population, both to acute mental health wards and to secure facilities (Davies *et al* 1996, Ciod *et al* 2000). Various conflicting theories attempt to explain this, ranging across a number of medical and social models, and giving differing weight to the impact of racism on the mental health of people from BME communities.

The rate of compulsory detention under the Mental Health Act 1983 is significantly higher for black people than that of the general population.

We will be looking in more detail about how black and minority ethnic people experience mental health services in London in Chapter 6, along with recommendations on how to tackle shortcomings in mental health services for these Londoners.

Asylum seekers and refugees are recognised to have high prevalence of mental health problems, despite the resilience and initiative shown by many on arrival in Britain.

What is the situation regarding refugees and asylum seekers?

Between 1996 and 2000, an estimated 217,000 asylum seekers and refugees are thought to have arrived in London (Greater London Authority/Mayor of London 2001). Applications for asylum can take a very long time, with 16 per cent taking longer than six months. In 2002, only 10 per cent of applications for asylum were granted, with 24 per cent being given exceptional leave to remain. Two-thirds were refused, and 76 per cent of appeals were dismissed (*Independent*, 23 May 2003).

Many of those who seek asylum and who are granted it, and many of those who stay illegally, remain in London. The Government aims to support asylum seekers through the National Asylum Support Service (NASS), by offering them accommodation outside south-east England plus subsistence, or subsistence only if they say they can find their own accommodation.

NASS attempts to spread refugees around the country, but for many, the desire to stay in London outweighs the appeal of taking up accommodation elsewhere, particularly given the lack of community support and networks in some parts of the country to which asylum seekers have been dispersed. As a result, in June 2001 more than 14,000 new asylum seekers lived in London on the basic 'subsistence-only' package of under £40 per week, and one-third of these lived in the four boroughs of Brent, Ealing, Haringey and Newham (Greater London Authority/Mayor of London 2001).

Asylum seekers and refugees are recognised to have high prevalence of mental health problems, despite the resilience and initiative shown by many on arrival in Britain. They have sometimes survived psychological distress as a result of the experiences they had prior to leaving their home country, their displacement, or from a pre-existing mental health problem. For example, an estimated 5–30 per cent of the proportion have been tortured, the effects of which may include depression or anxiety that, in a minority of cases, can require specialist psychiatric assessment and treatment (Burnett 2002). Moreover, poor housing and social conditions and the hostility that many asylum seekers encounter almost certainly compound any pre-existing mental health problems.

A study of the refugee population in Brent and Harrow found that self-reported mental health problems were more than five times higher than in the general population (Aldous *et al* 1999). Most mental health care for asylum seekers is currently provided in general practice, and it is not clear how this translates into need for specific services.

Although asylum seekers and refugees are eligible for free NHS care, they are not always able to access mainstream social support and mental health services. This may reflect a lack of knowledge of what is available, or a suspicion of using health services. It may also reflect barriers to access, such as the attitudes of some NHS staff, or language difficulties. Either way, the use of accident and emergency departments is higher among refugees than that of the host population (Aldous *et al* 1999).

Among those who seek asylum are many well-qualified people, including those with medical, nursing and allied professional experience.

According to Aldous, refugee registration with GPs is generally high (over 90 per cent), but the studies it describes are of refugees in established community groups. This conceals the numbers that only achieve temporary-resident registration with a general practice, who therefore miss out on routine health checks and health promotion. However, the introduction of personal medical services (PMS) into general practice has ensured that primary care is better tailored to meet the specific requirements of homeless and refugee populations (McKenna 2002, Lewis *et al* 2001).

A further reflection on asylum seekers is that among those who seek asylum are many well-qualified people, including those with medical, nursing and allied professional experience. Some of their qualifications are recognised in this country, but others are not. It is important to realise the extent to which asylum seekers are a resource, as well as being service users. In recent years there have been several projects to support asylum-seeking health professionals in training to build on their qualifications and get recognition for their professional skills, but much more could be done. The NHS needs to do more to make the most of the contribution that skilled people from a range of countries can make to mental health services here and now.

What are the characteristics of London's prison population?

The eight prisons in London contain 6,972 prisoners – almost 10 per cent of the total prison population of England and Wales, which in February 2003 was at 72,286 (Home Office 2003). Recent joint initiatives between the NHS and the Prison Service have seen a greater recognition of the levels of ill health, especially mental health problems, in prisoners. In particular, suicide or self harm by prisoners has been a major concern: in the past decade, 639 prisoners have killed themselves, and the rate has only reduced slightly in recent years. In addition, more than 1,500 prisoners attempted hanging or strangulation or suffocation in 2000 – a rise of 50 per cent since the previous year (Safer Custody Group 2001).

A national survey of prisoners' mental health found that 21 per cent of male remand prisoners and 18 per cent of male sentenced prisoners had received mental health care before entering prison (Singleton *et al* 1998). The proportions were much higher for female prisoners, with 40 per cent of both remand and sentenced prisoners saying that they had received help or treatment before entering prison.

Assessments of mental health in London prisons have produced similar results. In Brixton, for example, where there are about 750 male prisoners, 24 per cent of newly arriving prisoners were found to have a history of mental health problems, and 49 per cent had a history of substance abuse (Mountford 2001). A study in Holloway prison, where there are around 470 female prisoners, found that 10 per cent of women on remand had a diagnosis of schizophrenia or 'paranoid state' (Bird 1999). A shortage of NHS mental health beds – especially secure beds – has resulted in a backlog of 'prisoner patients' who would be better served in NHS rather than Home Office facilities (House of Commons Health Committee 2000).

What these figures do not tell us is how many people in London's prisons usually live in London. However, given the association between crime and deprivation, it

is reasonable to assume that London has at least its fair share of former – and future – prisoners. Assuming that the mental health problems experienced by so many prisoners are not fully resolved during their imprisonment, the mental health service needs of Londoners who have been in prison are likely to be considerable.

This point was particularly reinforced by the voluntary organisations that contributed to the King's Fund mental health inquiry. One group that works to support people leaving prison spoke of the very high rates of mental health problems in prison. They observed that on discharge, it was difficult to get ex-prisoners linked into ordinary services, and that there is often no information on the person's history or current needs available to pass on to GPs or specialist services. Getting ex-prisoners, who often have severe substance misuse problems, taken on by services was likened to:

> *... watching a game of tennis... What you find is these people bouncing in the middle, between services, until they no longer engage with services.*
>
> Participant, King's Fund discussion group

How is London affected by drugs, alcohol and dual diagnoses?

London appears to have particularly high levels of co-morbidity, or dual diagnosis. An estimated 30–60 per cent of people with mental health problems have a substance misuse problem and/or an alcohol problem (Sainsbury Centre for Mental Health 2002). However, co-morbidity does not only exist in the form of mental health problems alongside drug and/or alcohol problems. There is increasing recognition of significant numbers of people with personality disorders in addition to mental health problems. Their needs are very complex, and require particular expertise and a high level of specialised resources in order to optimise their care.

While dual diagnosis is not unique to London, there is a great deal of anecdotal evidence from service providers that it is more common in London than elsewhere, with a corresponding level of demand on London's mental health services, as well as being a very great challenge for the frontline staff. The 1997 King's Fund mental health inquiry did not quantify the extent of dual diagnosis at that time, but there is widespread agreement among people working in mental health services that the number of people with drug or alcohol problems in addition to a mental health problem has greatly increased since that time.

In a recent study in three inner-London psychiatric units (Phillips and Johnson 2003), ward staff were asked to rate whether inpatients with a diagnosis of functional psychotic disorder had also met criteria for a diagnosis of alcohol or drug misuse or dependence during the previous six months. Those who did were then asked to report the nature and extent of their substance use, and whether they continued to use as inpatients. According to staff reports, 127 out of 264 (48.9 per cent) met the criteria for substance use or dependence.

Phillips and Johnson state that this rate exceeds that reported in other UK community studies (Menezes *et al* 1996, Wright *et al* 2000, McCreadie 2002). In

An estimated 30–60 per cent of people with mental health problems have a substance misuse problem and/or an alcohol problem.

the Phillips and Johnson study, the mean age of those with dual diagnosis was 34.7 years and 72 per cent were male. More than four-fifths (83 per cent) of those with a history of current or recent alcohol or drug misuse reported that they had continued to use alcohol and/or illicit drugs in the inpatient wards during their current admission.

Substance-use services report that 50 per cent of substance users have a co-morbid mental health problem and between 3,500 and 7,700 patients admitted for psychiatric treatment each year in London are likely to have a drug misuse problem (Greater London Alcohol and Drug Alliance 2003). Generally, drug misuse is concentrated in areas with high deprivation, homelessness and unemployment – areas most commonly found in inner cities (Bird 1999).

The fact that London is a young city also affects its rate of substance use. Over half of young Londoners drink excessively on a regular basis and have tried an illegal drug (London NHS Confederation 2003a). In a recent report, London had the highest proportion in Britain of people reporting having used illegal drugs: 16 per cent of Londoners claimed to have used illegal drugs in the previous year, compared with 11 per cent in Britain as a whole (Singleton *et al* 2001). London also contained particularly high proportions of female cannabis and cocaine users (14 per cent and 4 per cent respectively) compared with the average in Britain (7 per cent and 1 per cent respectively).

At a conservative estimate, there are 70,000 problem drug users in London, with 'problem drug use' defined as where the pattern of drug use, or the way drugs are taken, causes significant physical, psychological, financial or social problems for the user, or problems for the wider community (Greater London Alcohol and Drug Alliance 2003).

Professional opinion varies on the role of so-called 'recreational' drugs as causal factors in the development of some mental health problems, and mental health problems themselves can also lead to drug use (Hunt and Ashenhurst 2001). Moreover, the growing use of recreational drugs among Britain's young population means that drug use and mental health problems will be associated together more frequently, regardless of any real causal link between them in individual cases.

The relationship between mental health problems and alcohol are equally complex. In one 12-month period, 72,500 patients across Britain were admitted to hospital with a diagnosis of mental and behavioural disorders due to alcohol (Department of Health 1999b). Another study found that 65 per cent of suicides in Britain were linked to excessive drinking (Department of Health 1993) though it is not clear whether alcohol use contributed to the suicide, or whether high alcohol use was an indication of their level of distress.

Conclusions

In this chapter, we have looked at the factors that make London different from other cities. Some of the differences are a matter of scale: all cities experience challenges – London simply has more of them. Some of them reflect London's particular demography, such as the age and ethnic profile of its people, others are about income and lifestyles.

London is often talked about as though it were a homogenous mass. In fact, it is a complex network of different communities, and this is reflected in the fact that service provision does not necessarily correspond to the prevalence of mental health problems. For example, some primary care practices have large numbers of people with mental health problems because a general practice is situated near supported accommodation for people with mental health problems, or because a particular GP is known to have a particular interest in mental health. Some parts of London have much higher spending on mental health secondary care and specialist services than others.

There are other inequalities too. For example, there is almost a four-fold variation between the number of acute beds per 100,000 population in Bromley and that of Camden (McCrone 2003, MHI Working Paper 7). Later in this report (in Chapter 6), we consider whether this reflects local variations in need, or whether it is influenced by other factors.

All of this results in a paradox for London. Some of its characteristics require more centralisation and greater co-ordination – for example, to improve pan-London work on housing needs related to mental health needs. Other characteristics, such as its ethnic diversity, require highly decentralised approaches and more differentiated local responses. All of them have some impact on levels and types of mental health needs in London, the services available and the problems facing them.

Part 2
Research findings

4 Commissioning →

This chapter sets out the differences between how mental health services were commissioned in 1997 to the current situation in:

- staff resources available for commissioning
- the relationship between PCTs and service providers
- joint commissioning
- the fragmentation of mental health commissioning.

4 Commissioning

Commissioning of mental health services is still weak and under-developed in many parts of the capital. The amount of time devoted to commissioning mental health services, and to developing mental health services in primary care, varies from one primary care trust to another, but the overall impression is that insufficient time, expertise or resources are available to mental health commissioning in primary care. This places PCTs at a major disadvantage when negotiating with their larger and more expert trust partners. Moreover, the separate endeavours of PCTs remain uncoordinated at a London-wide strategic level, despite many local partnerships.

There are real tensions between the benefits of local commissioning and the potential problems arising from the dilution of expertise across a large number of commissioners. No solution can eliminate these tensions completely, and the best ways forward must capitalise on the strengths of local knowledge, while combining forces for the common good, across agency and geographical boundaries, where necessary.

What was the situation in 1997?

When the first King's Fund mental health inquiry reported in 1997, the word 'commissioning' did not appear, although there was a detailed analysis of 'purchasing' activities by health authorities. Commissioning, with all it entails, has been a latter-day development. A helpful summary and discussion of the evolution of purchasing into commissioning (in the five years following the introduction of the NHS internal market in 1991) was published in a background paper to the Bristol Royal Infirmary Inquiry (Bristol Royal Infirmary Inquiry Secretariat 1999).

What has changed since 1997?

In spite of developments in commissioning after the period described by the Bristol Royal Infirmary Inquiry, many commentators would argue that the effectiveness of commissioning has a long way to go; and in the mental health field, commissioning seems particularly patchy and under-developed.

There are real tensions between the benefits of local commissioning and the potential problems arising from the dilution of expertise across a large number of commissioners.

There is still some confusion between purchasing and commissioning. In its *Commissioning Drug Treatment Systems* resource pack, the National Treatment Agency for Substance Misuse (NTASM) states that 'it is... important to differentiate between commissioning and purchasing... although the terms are often used interchangeably' (National Treatment Agency for Substance Misuse 2002, Section 1).

The definitions in the box overleaf are cited from Section 1 of the NTASM resource pack. Although they are widely accepted in principle, the reality is that both conceptually and in fact, the terms are used loosely. For example, Newham Primary Care Trust states that:

The commissioning directorate [is] responsible for overseeing the commissioning (that is, purchasing) of healthcare services for the people that live in Newham. Commissioning means deciding what services are needed, how much can be spent and who will provide the services.

Newham PTC website, available at: www.newhampct.nhs.uk

TERMS AND DEFINITIONS

- ***Commissioning*** *is the strategic activity of assessing needs, resources and current services, and developing a strategy to make best use of available resources to meet identified needs. Commissioning involves the determination of priorities, the purchasing of appropriate services and their evaluation.*
- ***Purchasing*** *is the operational activity set within the context of commissioning, of applying resources to buy services in order to meet needs, either at a macro/population level or at a micro/individual level.*
- ***Joint commissioning*** *is the process in which two or more organisations act together to co-ordinate the commissioning of service(s), taking joint responsibility for the translation of strategy into action. Joint commissioning should also be seen as:*
  - *a strategic activity for agencies to share and discuss their overall perspectives and strategies*
  - *a more detailed problem-solving tool for tackling specific difficulties.*
- ***Joint purchasing*** *is where two or more agencies co-ordinate the actual buying of services, generally within the context of joint commissioning.*

National Treatment Agency for Substance Misuse (2002, Section 1, para 2)

What skills and resources are available for commissioning?

During the course of the 2003 King's Fund mental health inquiry, responsibility for commissioning most mental health services passed from health authorities to PCTs. PCTs had only recently been formed, and in many respects their duties, responsibilities and level of autonomy were quite different from the PCGs that had preceded them. So it was timely for the inquiry to commission research on mental health services in primary care that looked at both commissioning and delivery of mental health services in primary care (Rosen and Jenkins 2003, MHI Working Paper 2).

The researchers on the working paper conducted telephone interviews with mental health leads in 27 of London's 32 PCTs. The questions addressed issues such as:

- the staffing available to mental health commissioning and service development
- the levels of experience of the staff involved
- the available budgets for mental health.

The results from the telephone survey showed that:

- The amount of dedicated management time available for mental health commissioning and service development varied considerably. The mental

There is no rational basis for the variation in the amount of time allocated by different PCTs to mental health commissioning.

health leads surveyed had been in post in their current or a precursor organisation for between two weeks and five years (five had been in post for eight months of less), and dedicated between 0.5 and 10 sessions a week to mental health commissioning.

- All but one of those with few sessions dedicated to mental health and multiple areas of responsibility was assisted by one or more additional staff members.
- Only one PCT reported having a full-time employee dedicated to primary care mental health services. Other PCTs were supporting the development of primary care services in a variety of ways. These included commissioning sessional support from audit facilitators, development community psychiatric nurses, lead GPs and others.

The fact that PCTs were new organisations would go some way towards accounting for the fact that some did not yet have all their staff in place. It may also explain the finding that some of the mental health leads interviewed had been in their current (or equivalent post in the precursor PCG) for as little as two weeks, while others had been in post for five years.

The professional backgrounds of the mental health leads varied too. Eleven had some form of mental health training. Five were former psychiatric social workers, one was a public health doctor, two had experience of clinical psychology and two were registered mental health nurses.

Research carried out for the King's Fund found that there were major variations in the number and type of staff (if any) supporting the mental health leads. One PCT had a full-time development worker dedicated to primary care mental health services and one had a part-time facilitator (MHI Working Paper 2, Rosen and Jenkins 2003).

Although this research was a snapshot at a particular time in the earlier stages of PCT development, the picture of uneven allocation of resources is borne out by other King's Fund research (Aziz *et al* 2003, MHI Working Paper 6) – *see* Chapter 9 on finances. It is not clear from the available data whether the level of experience and expertise at PCT level has had a significant impact on the amount of resources available for mental health, or on the deployment of those resources for different kinds of mental health services. However, it may be reasonable to conclude that:

- There is no rational basis for the variation in the amount of time allocated by different PCTs to mental health commissioning. It follows that those with less time available to mental health leads may be less effective in making a difference to mental health developments.
- Most PCTs appear to have been unable to devote as much time to mental health commissioning as might be expected from the size of their budgets, or as required, given the state of development of mental health services.
- There is no evidence that the core skills required to be a mental health commissioner have been defined – let alone sought – in recruiting people into posts as mental health commissioners. So variations in expertise may be expected to be reflected in the depth of analysis and influence that mental health commissioners are able to apply.
- Current arrangements for performance management are inadequate for tackling the wide variations in commissioning mental health services, and to drive up the quality of mental health commissioning across the capital.

What is the relationship between PCTs and their service providers?

Mental health commissioning in London is also a challenge because of the comparatively small size of PCTs compared to the trusts from which they commission services, which during a similar period in London have been growing larger and more powerful. This inevitably impacts on the relationship between PCTs and trusts. There are advantages to being a relatively small, locally focused organisation, particularly in terms of:

- the lack of unwieldy bureaucracy
- simpler communications within the organisation
- the possibility of being close to the local community
- cohesion and a shared sense of purpose.

However, in the context of commissioning mental health services, the question is whether those potential advantages are outweighed by actual disadvantages, such as:

- insufficient management resource and infrastructure
- small size of budget
- insufficient purchasing power for the effective negotiation of price and quality
- ability to devote a sufficient amount of expert time to mental health commissioning
- duplication of effort between neighbouring PCTs and/or PCTs with similar issues and challenges.

Rosen and Jenkins observe:

> ..... *mental health leads often lack the experience, knowledge and adequate support staff to deal with commissioning and service development across the whole mental health agenda. While some PCTs outside London have tried to overcome these problems by establishing purchasing consortia, the situation is more complex within the capital. Mental health trusts have been merging into ever-larger organisations, while purchasers are becoming smaller, making consortium arrangements harder to establish. All of these issues are compounded by several rounds of organisational change, which have precipitated multiple staff changes and disrupted established relationships.*
>
> Rosen and Jenkins (2003, MHI Working Paper 2, p 46)

It may be conceded that many of these observations about mental health commissioning apply equally to commissioning other kinds of services. However, the wide variations in available time and expertise, the variability of mental health services across London, and the historic lack of priority given to mental health make it a particular issue for the commissioning of mental health services.

What roles do local authorities play in commissioning?

During the period since the last mental health inquiry, joint commissioning of mental health services has become increasingly important. Reed describes joint commissioning as an activity that focuses agencies on:

- *pooling information*
- *combining expertise*
- *agreeing main programme activities*

- *taking decisions collaboratively on resource development*
- *acting jointly through the planning and purchasing of services.*

Reed (2002, p 1)

The issue of fragmentation of mental health commissioning is discussed below. However, it must be recognised that the co-terminosity of PCTs and local authorities in London facilitates joint planning and joint commissioning. This is seen by many people as one of the chief strengths of retaining a significant role for local PCTs in commissioning mental health services. This strength needs to be considered alongside the counter-balancing view that mental health commissioners in London are too small and fragmented to be as effective as they need to be, to better address the needs of Londoners with mental health problems.

How does the high number of PCTs in London affect commissioning?

The large number of PCTs in London appears to lead to fragmentation in mental health commissioning. Although some services are commissioned on a wider basis than that of a single PCT (and there are instances of one PCT taking the lead for a particular kind of commissioning on behalf of other PCTs), overall these approaches have not yet made significant inroads into the variability in services across London. Most professional and lay opinion views this variability as being rooted in history rather than in current needs, and therefore as an issue in need of attention across the capital.

Challenges

Despite efforts across the board to work in partnership within local areas, the lack of a co-ordinated approach persists. However, in MHI Working Paper 2 (Rosen and Jenkins 2003) all the telephone survey respondents reported that community mental health services were now provided jointly by health and social services. Getting to that stage had often been a major developmental challenge. Several PCT leads reported that their role in this process, and the successful launch of their community mental health teams was one of their greatest recent achievements – although they acknowledged that the development of integrated community mental health teams had begun many years ago, before the PCTs came into being.

What co-operation does exist is largely there to ensure that particular services are delivered. Important though this is, it does not address the significant lack of a unified strategic perspective for London. Nor does it provide a way forward to address mental health issues and mental health services that cut across boundaries of boroughs and PCTs.

What co-operation does exist does not address the significant lack of a unified strategic perspective for London.

No doubt, as strategic health authorities develop in their new roles, aspects of this may be addressed, but London would still run a high risk of having five approaches to mental health, rather than one. Since so many of the solutions to the city's mental health problems (including workforce, housing, and so on) are capital-wide, it is hard to see how even the most strenuous attempts at partnerships between commissioners, or between commissioners and providers, can truly succeed in the absence of a co-ordinated approach to mental health in London.

Conclusions

Weak commissioning

Mental health commissioning in London is weak and underdeveloped. It varies in quality from one PCT to the next, and different PCTs devote different levels of time to it. The reality is that the process of commissioning mental health services in London comprises a set of ill-matched dialogues between a small number of large mental health trusts and a much larger number of fairly weak and under-developed PCTs. Some specialised mental health services are commissioned on a lead-commissioner basis, and the model currently used for specialist commissioning could be developed to include most mental health services. Overall, the picture is one of duplication of effort, with expertise thinly spread. Even allowing for the newness of these commissioning organisations, something must be done to improve mental health commissioning as a matter of urgency.

That is not to suggest that all aspects of commissioning mental health services in London should be wrested from the organisations that currently commission those services. It is important to ensure that London PCTs retain a major interest in the mental health of their local populations – for prevention, health promotion and service development alike. No one is better placed to take a lead on assessing local need than the PCTs and their partners in the local health economies.

However, the nuts and bolts need not be done at a very local level. Detailed work on contracts can certainly be done in a more co-ordinated manner. Discussions and negotiations about new ways of configuring services may also have a greater chance of success where the several PCTs that look to one particular mental health trust work together to commission services. Above all, we need to find ways to retain engagement and ownership at a local level, while developing expertise and commissioning skills at a less local level, in line with a strategic approach for London.

At whatever level commissioning takes place, those who actually work as commissioners in mental health need to be able to access support. A network of London's mental health commissioners has already begun to meet under the aegis of the London Development Centre for Mental Health, and has proved popular. We strongly endorse this approach to supporting commissioning mental health services in London, both for those aspects that should continue to be done at a local level, and for prospective and actual lead mental health commissioners in the future.

Weak performance management

Performance management must be combined with supporting and developing leadership for commissioners and providers of mental health services.

Calling for effective performance management is hardly the kind of recommendation to excite people. Some people at a local level feel that they are performance-managed to within an inch of their lives as it is. Yet variations in commissioning and in service provision (as discussed in Chapter 6) suggest that mental health services are evidently not performance-managed as effectively as they could be, since wide gaps in provision and variations in quality and provision that are unrelated to need still persist.

In theory, a variety of mechanisms for improving performance management are possible, but it is important to avoid creating new bodies with performance

management functions specifically for mental health. Instead, it would seem sensible to build on arrangements that are already in place and are beginning to become more effective, and to continue to vest these powers in the strategic health authorities, developing the role of the lead one. This suggestion goes hand-in-hand with developing a London mental health strategy, since progress at a local level will need to be managed within the context strategic aims for London's mental health.

The challenge for developing more effective performance management of London's mental health services is not just a matter of becoming more rigorous. What is needed is the setting of clear standards, with the involvement of service users and carers, together with effective and accessible support to ensure that standards can be met. Performance management must be combined with supporting and developing leadership for commissioners and providers of mental health services. Within these frameworks, peer group support, through networks of mental health commissioners and providers, should also play an important part.

Recommendations

- ☑ PCTs, in co-operation with their local authority partners, need to identify a lead PCT in each strategic health authority to undertake those aspects of commissioning that would benefit from sector-wide commissioning.

- ☑ Strategic health authorities must take responsibility for ensuring that lead commissioning arrangements are in place and for resolving disagreements between PCTs on commissioning decisions and priorities.

- ☑ Each PCT, in co-operation with its local authority partners, should retain the responsibility for assessing local needs and ensuring that they are being met, and for commissioning small-scale services to meet very specific local needs. However, detailed work on service specifications and the contracting process would best be undertaken by the identified lead commissioner on behalf of the other PCTs in the sector.

- ☑ Given that commissioning is still a new and developing skill, the London Development Centre for Mental Health needs to work with the King's Fund and other developmental and educational bodies to establish a Centre for Excellence in Commissioning as a resource for commissioners.

- ☑ The National Institute for Mental Health in England, through the London Development Centre for Mental Health, must work with other relevant organisations to improve support for providers of mental health services in London and to facilitate access to support and development, especially for those in a leadership role in mental health.

- ☑ Strategic health authorities need to strengthen their performance management of mental health services in London, with an emphasis on achieving equity in relation to need in services across London in the context of a London mental health strategy.

5 Primary care

This chapter asks how far primary care has come in addressing the difficulties it was facing in 1997. Issues highlighted include:

- changes in the policy context
- the variation in services across London
- the capacity of primary care to meet mental health demands
- access to counsellors and other specialist mental health professionals
- the overall progress in implementing the NSF-MH in primary care.

5 Primary care

Most of the persistent difficulties facing primary care in relation to mental health services are old and familiar problems. Demands are heavy, skills (nurtured by education and training) are underdeveloped, and national priorities do not always give adequate support to primary care. Additional funding may not be finding its way to primary care as much as it should, and there is a risk for the future if monies cannot be better identified and tracked in order to improve primary care. Primary care trusts (PCTs) should identify a budget for mental health services to support the implementation of priority developments.

At the same time, recruitment and retention of GPs remains a major issue, while the provision of other staff, such as counsellors and psychologists remains uneven. The possible solutions to recruitment and retention problems go wider than the primary care setting, and are discussed further in Chapter 10, on workforce issues. However, if an adequate supply of primary care professionals is to be found to work with people with mental health problems, either as generalists or as specialists, the issues that are identified in this chapter need to be addressed in order to support them in their tasks and encourage them to stay in their posts.

The fact that this catalogue of problems is so familiar is somewhat dispiriting. However, it remains it be seen how far and how fast PCTs can develop the required competence, confidence and clout to develop services in general practices and in the community. Rosen and Jenkins suggest that a primary care mental health champion is urgently needed in each PCT to lead developments in general practice settings, although they point out that this post would need to be funded for several sessions per week in order to have a real impact (Rosen and Jenkins 2003, MHI Working Paper 2).

What was the situation in 1997?

At the time of the 1997 King's Fund inquiry, the deficiencies of primary care in London had been under the spotlight (Johnson *et al* 1997). Following the Tomlinson Report (Department of Health 1992), a number of important changes were set in motion, and considerable investment was made. The creation of the London Implementation Zone (LIZ) allowed family health service authorities (FHSAs) to make bids for extra funding. LIZ funding was widely used to introduce a variety of mental health initiatives across all health authorities.

Demands are heavy, skills are underdeveloped, and national priorities do not always give adequate support to primary care.

Various measures were introduced at practice level to improve primary care for people with mental health problems. These included case registers, practice protocols, agreed care plans and mental health facilitators. However, while examples of good practice were cited, where individual general practices had developed effective in-house services and good links with external services, these were seen as the exception rather than the rule.

The 1997 mental health inquiry concluded that mental health services in primary care were of generally poorer quality than those elsewhere in the country, and lamented that GPs appeared often to lack fundamental skills and knowledge in the management of mental health problems. It observed that the distribution of mental health professionals in primary care was patchy, recommending:

- *That a high priority be given to training of primary care staff, with a focus on the detection and management skills of GPs and practice nurses.*
- *Community Mental Health Teams (CMHTs) should consider ways of increasing integration with primary care services (possibly including aligning boundaries to general practice populations, developing shared care registers and establishing clinics by psychologists and psychiatrists in larger practices).*

Johnson *et al* (1997, p 371)

What has changed since 1997?

What has changed in the policy context?

There have been many changes in developments in mental health services in primary care since the 1997 inquiry, and the policy context in which they are delivered has moved on rapidly. In addition to the broad mental health policy developments outlined elsewhere in this report, primary care in mental health, as in other clinical areas, is being shaped by drug developments, clinical service innovations, workforce trends, national policy priorities and NHS reorganisations.

The National Service Framework for Mental Health

What has changed?
Many of the important changes for mental health were signalled in *Modernising Mental Health Services* (Department of Health 1998a) and were taken forward in the National Service Framework for Mental Health (NSF-MH, Department of Health 1999a).

What has this meant for primary care mental health services?
As we saw in Chapter 2, the introduction of the NSF-MH has focused minds on tackling mental health issues and services, but in spite of its recognition of the importance of high quality mental health services in primary care, the implementation priorities have mostly been focused on people with severe mental health problems.

The implementation priorities of the NSF-MH have mostly been focused on people with severe mental health problems.

We have already seen the impact of organisational changes on commissioning within primary care trusts, and these changes have had just as much impact on the work of GPs, and their primary care colleagues, in delivering services. The introduction of PCGs and their evolution into PCTs has brought about both opportunities and constraints.

In 2000, one-third of PCGs identified mental health as an early priority for health improvement (Wilkin *et al* 2000), and the following year 40 per cent had increased the amount of counselling services they commissioned (Wilkin *et al* 2001). There

were also examples of improved partnership working between community health and social care practitioners, and developments in joint investment for mental health services.

Primary care mental health is also working within a changing clinical and professional context. As we shall see in Chapter 10, on workforce issues, there are doubts as to whether the Government's targets for recruiting additional GPs can be met. Indeed, a large cohort of London's GPs are approaching retirement, and replacing them will be a challenge in itself.

(*See also* What overall progress has been made in implementing the NSF-MH in primary care?, p 69.)

PMS contracts

What has changed?
During the past few years, London has seen widespread introduction of personal medical services (PMS) contracts, linking primary care development to local health needs, and allowing more flexible working patterns than the traditional GP contract. Some PMS pilots are focused on under-privileged areas and deprived social groups, in which there is a higher than average prevalence of mental health problems.

What has this meant for primary care mental health services?
In the future, these developments may play a key role in better meeting the needs of those Londoners with mental health problems who have found it difficult to access good primary care. PMS schemes may be of particular benefit to black and minority ethnic (BME) communities, particularly if they live in areas that have historically had under-developed primary care services. However, it is also important that the needs of BME communities are seen as part of the core business of primary care in London.

GP roles

What has changed?
GP roles are also undergoing a process of change. The NHS Plan announced an intention to introduce specialist GPs. In June 2003, GPs accepted a new General Medical Services (GMS) contract, which will be fully implemented from April 2004. This includes a 'quality and outcomes' framework, which resources and rewards GPs on the basis of how well they care for patients, rather than simply the number of patients they treat. This is intended to improve chronic disease management in the community, and may improve primary care for people with mental health problems.

Primary care has also been working hard to achieve stringent access targets to provide routine access to a GP within 48 hours, and great strides have been made with this important development. The NHS Plan stated that by 2004, patients would be able to see a primary care professional within 24 hours, and a GP within 48 hours. By March 2003, 90 per cent of patients in practices that had an appointments system were expected to offer an appointment to see a GP within two days.

What has this meant for primary care mental health services?
The new GMS could have a major impact on how mental health needs are met in primary care, although it is not clear at this stage what impact introducing GPs with a special interest in mental health would have on the demands on their GP colleagues who do not have specialist mental health expertise.

The new access targets will benefit people with mental health problems, as well as others, as they reflect changing public expectations, and a greater commitment to work toward a user-centred service. It is often said (although rarely substantiated) that the public is becoming more demanding of health services. Whether or not that is true, it is likely that the many and varied pressures on GPs and others working in primary care contribute to a feeling of trying to spin too many plates at once.

Nurses

What has changed?
Developments in primary care are not restricted to GPs. An increasing number of nurse-led services are being developed in primary and secondary care.

What has this meant for primary care mental health services?
This may impact as much on services for people with mental health problems as those with entirely physical ailments. NHS Direct also plays a part, by giving advice on mental health. Although the experience of mental health among NHS Direct nurses is variable, this is a developing field of expertise.

Mental health workers

What has changed?
In July 2000, the Prime Minister announced plans for a cadre of 1,000 graduates to be engaged as mental health workers in primary care. These workers were envisaged as likely to be people with a first degree in psychology, with training in effective brief therapy. Although they will add to the evolving skill mix of primary care professionals in mental health, this has been a highly controversial proposal – welcomed by some, and greeted with less enthusiasm by others. Their projected role has now been modified so that their tasks will mainly entail assessment and helping primary care professionals.

What has this meant for primary care mental health services?
Commentators such as Graham Curtis Jenkins, Director of the Counselling in Primary Care Trust (2001) have advanced a number of concerns about how the idea might work in practice, and what it might cost to implement. It will be important to define clear roles for these workers, and to provide them with adequate support.

Funding in primary care

What has changed?
The financial context for mental health in primary care is hard to grasp. In the absence of an annual NHS reporting system for mental health expenditure, trends in available resources are not easily identifiable – an issue that is discussed further in Chapter 9, on finances.

Little of the additional £700 million of mental health funding announced in 1999 will have reached primary care services.

Glover (1999) developed a methodology to estimate how much of each health authority's per capita health funding was weighted for mental health and learning difficulties. He then attempted to compare this with estimated spend on mental health. While he identified wide variations in the ratio of weighted allocation to estimated spend, because of the methodological problems associated with the work, it can only be a rough guide to the overall figures. In the absence of national data on overall income and spend, it is extremely difficult to estimate what proportion of the mental health budget flows into primary care services. This difficulty needs to be addressed – with some urgency – in the future.

However, in view of the stated priorities for mental health, it seems that little of the additional £700 million of mental health funding announced in 1999 (to be spread over three years) will have reached primary care services. Key early priorities for this funding were more beds (in hostels and secure units).

The NHS Plan's priorities for service development included crisis resolution, outreach teams and 24-hour access, new treatments (including atypical neuroleptic drugs), and staff training. While these are all important for mental health in general, staff training and the new drugs will impact directly on primary care services. The attention paid to the atypical anti-psychotic medications is important, as in recent years there has been a substantial rise in prescribing of these medications in primary care.

What has this meant for primary care mental health services?
As widely suspected, and now confirmed by the Audit Commission (Audit Commission 2003), only half of PCTs and mental health trusts (and nearly two-thirds of acute trusts) have adequate arrangements for ensuring that growth monies were allocated for their intended purposes. In some cases, growth monies are used for recovery funds and to cover deficits, rather than for the specific purposes for which they were intended.

Even where that is not so, new money has a habit of disappearing before it can fund growth. Additional staffing on-costs have to be met, and long-standing understaffing in primary care can result in new funding going into recruitment rather than service development. In addition, retention problems can result in high spending on successive waves of recruitment, and on temporary and agency staff. Finally, the long-standing deficiencies in secondary care require funding simply in order to bring inpatient facilities up to modern standards, thus pushing primary care even further to the back of the queue.

How do mental health services in primary care vary across London?

It is difficult to quantify the demands on primary care from people with mental health problems. This is partly because although one-third of GP consultations have a mental health component, 30–50 per cent of people with mental health problems are not initially acknowledged by GPs as having such a problem, although the accuracy of diagnosis increases to 90 per cent over three to four consultations (Cohen 2002).

There are local variations in prevalence for many other reasons too. For example, if a general practice is near supported accommodation for people with mental

health problems, or if a GP has a particular interest in mental health, the GP's caseload of people with mental health problems may reflect those factors.

A further issue of great importance is that imbalances in the systems for caring for people with mental health problems may have particularly negative consequences for some sections of the population. For example, Keating *et al* (2003, MHI Working Paper 5) confirm that people from black and minority ethnic communities are still over-represented in acute inpatient wards, suggesting that people from BME communities are not getting the best possible care from primary care and community-based services. They also state that BME women are more likely to visit and receive treatment at primary care level than other women, but that their experiences and outcomes within primary care are poor. Asian women – particularly young Asian women – tend not to use GP services as a pathway to care because of fears about confidentiality.

Service users at the 2003 King's Fund mental health inquiry discussion groups reported very different experiences of primary care. Some said that primary care does not see mental health as a priority, and that the physical health problems of people with mental health problems are ignored. Others, on the other hand, spoke of 'wonderful' GPs who provided excellent support. Problems of variability in GP services persist. However, all the service users participating in discussion groups wanted better primary care, and wanted to be able to use primary care much more. They did not think it was good enough if it was the case that other groups were prioritised by primary care while mental health service users were seen as 'little better than a nuisance':

> *[GPs] need a wider scope of mental illness and to accept what the patient is saying and don't just fob him off with a story.*
>
> *They want to ask you what medication you are on and what medication you are taking, but they don't put a lot of effort into anything else.*
>
> *I don't know what would have happened without my GP, who is wonderful.*
>
> Participants, King's Fund discussion groups

What is the capacity in primary care to meet mental health demands?

Since the role of primary care professionals in caring for people with mental health problems is crucial – and will remain so, it is useful to review the capacity of general practice to do what is required. On the positive side, developments in London since 1997 include further investment in GP premises and more funding for GP education, and most practices are now computerised. However, it remains difficult to recruit GPs in London – particularly to those areas where there is the greatest need. It still remains true that London has a higher-than-average prevalence of single-handed GPs, poor premises and lower scores on quality measures than elsewhere.

London has a higher-than-average prevalence of single-handed GPs, poor premises and lower scores on quality measures than elsewhere.

To gather data on education and training for GPs, Rosen and Jenkins (2003, MHI Working Paper 2) carried out research and sent a postal questionnaire to a 20 per cent sample of London GP practices, stratified by the size of the practice. They also carried out a telephone survey of PCTs asking about the involvement on education and training for primary care professionals.

They found that:

- One-third of practices responding to the questionnaire had organised some kind of in-practice training in mental health.
- Nine per cent had undertaken mental health needs assessment for their staff.
- Educational activity included case-note review, critical-incident analysis, talks from visiting speakers and sending staff on courses.
- Few PCTs were arranging education and training on mental health topics for primary care staff.
- Only three PCTs surveyed had a dedicated budget for mental health education and training.

Overall, it is still the case that education and training in primary care is woefully underdeveloped in enabling people to work confidently and competently with people with mental health problems.

What access to counsellors and other specialist mental health professionals is available in primary care?

In 1997, the report of the King's Fund mental health inquiry stated:

> *There should be a more equitable distribution of counsellors and psychologists between general practice surgeries. These attachments are probably best administered from outside the practice, using professionals with appropriate qualifications.*
>
> Johnson *et al* (1997, p 131)

By 2003, the following improvements in the provision of counsellors had taken place, though equity was still a distant goal:

- Four-fifths of responding practices had access to counsellors in their own or neighbouring practice (although two-thirds of counsellors were available for only one or two hours a week).

Between 70 and 80 per cent of practices also had access to other cognitive and brief psychological therapies, bereavement and stress counselling, and eating disorder groups (Rosen and Jenkins 2003, MHI Working Paper 2, p 21).

What overall progress has been made in implementing the NSF-MH in primary care?

The NSF-MH appears to be making some difference in focusing attention on identified mental health priorities, but its implementation is patchy. Also, many of the priorities address the needs of people with serious mental health diagnoses, rather than those with less serious problems. Important as those needs are, the current prioritisation may hinder mental health services in primary care, rather than helping.

Approximately one-third of responding practices were involved in some way with NSF-MH implementation – most commonly:

- guideline implementation

There is a constant risk that the needs of the large numbers of people with less severe mental health problems become marginalised.

- audit of clinical practice against NSF-MH-linked standards
- data collection to monitor progress with NSF-MH
- education and training activities.

Just over one-quarter of the practices that responded reported using guidelines for the management of at least one mental health condition, but a very small proportion audited their use.

It is difficult to get an overall picture of how the implementation of the NSF-MH is perceived by those working in primary care, or how they feel about the overall quality of mental health service. Forty-two per cent of questionnaire respondents felt that services were a little or much better than three-to-five years ago while 29 per cent felt they were a little or much worse. Almost half (46 per cent) felt that communication and liaison between primary care and specialist mental health services was a little or much better than it was three-to-five years ago, while 28 per cent felt that communication and liaison were a little or much worse. It is not known whether differences in the opinions of GPs reflect service developments in their local areas, or the expenditure on local mental health services.

Many of the issues that the primary care professionals felt were problematic related to services outside the direct control of individual GPs (although they are clearly part of the solution for communication and liaison issues). For example, they mentioned:

- staffing, and availability of specialists
- problems with liaison and communication
- problems with access to services, particularly in emergencies
- inadequate resources.

They also cited problems with specific services, such as drug and alcohol, and child and adolescent services. However, there was no clear, overall consensus in primary care about which services were good and which were bad. The greatest differences in opinion related to services for homeless people, refugees and people with addictions, where a majority of respondents felt there were significant problems.

Challenges

One of the most significant challenges for the development of mental health services – in London, and elsewhere – is to achieve a reasonable balance between the needs of those people with severe and enduring mental health problems, and those who have less serious difficulties but who still require significant amounts of treatment, care and support. This second group is larger, and needs a great deal of continuing help from primary care professionals.

Given the current political climate and prevailing public opinion (and it is difficult to separate out the relationship between the two), there is a constant risk that the needs of the large numbers of people with less severe mental health problems become marginalised while every effort is put into services for people whose mental health problems put themselves, or others, at more obvious risk.

This is clearly a problem for people who are not receiving the support they need to live their lives as fully and healthily as possible. It is also a problem for primary care: the demands on GPs, practice nurses and others do not diminish simply because so much energy is devoted to implementing other mental health priorities. Indeed, the demands on primary care are probably increasing as Department of Health guidance asks community mental health teams to screen, prioritise and gatekeep access, and redirect patients with less severe problems to primary care. That is not to say that people with severe mental health problems are getting all that they need, but that is a story for later in this report (*see* Chapter 6).

Overall, looking at the situation for mental health in primary care, it is difficult to say whether the glass is half full or half empty, and the views of those working in primary care appear to be divided too. As we shall see in more detail in the following chapter, all is not rosy in the specialist mental health services, and shortcomings in other parts of health and social care services have a significant knock-on effect on primary care. While retaining a clear focus on mental health services in primary care, it is also necessary to look again at how all the pieces of the jigsaw fit together.

Conclusions

Primary care professionals offer treatment and care for people with all kinds of mental health problems, including people with high levels of need who use specialist services, and those with less severe difficulties. They need to be skilled in offering services that help to prevent deterioration in the mental health of their patients, as well as caring for people during crises, and in periods of recovery and rehabilitation. They also need to provide high quality physical health care for all of their patients, whether they have severe, or less severe and enduring, problems. While there has been some movement since the report of the last inquiry, it is clear that much more is needed in offering adequate training and skills development to primary care professionals.

In addition, the range of skills that primary care can access – such as counselling and psychology services – needs to be more equitably distributed and aligned with local needs. The needs of black and minority ethnic communities need to be addressed more comprehensively and more sensitively within primary care, as part of a broader plan to achieve a better range of culturally sensitive services for London's diverse communities.

Recommendations

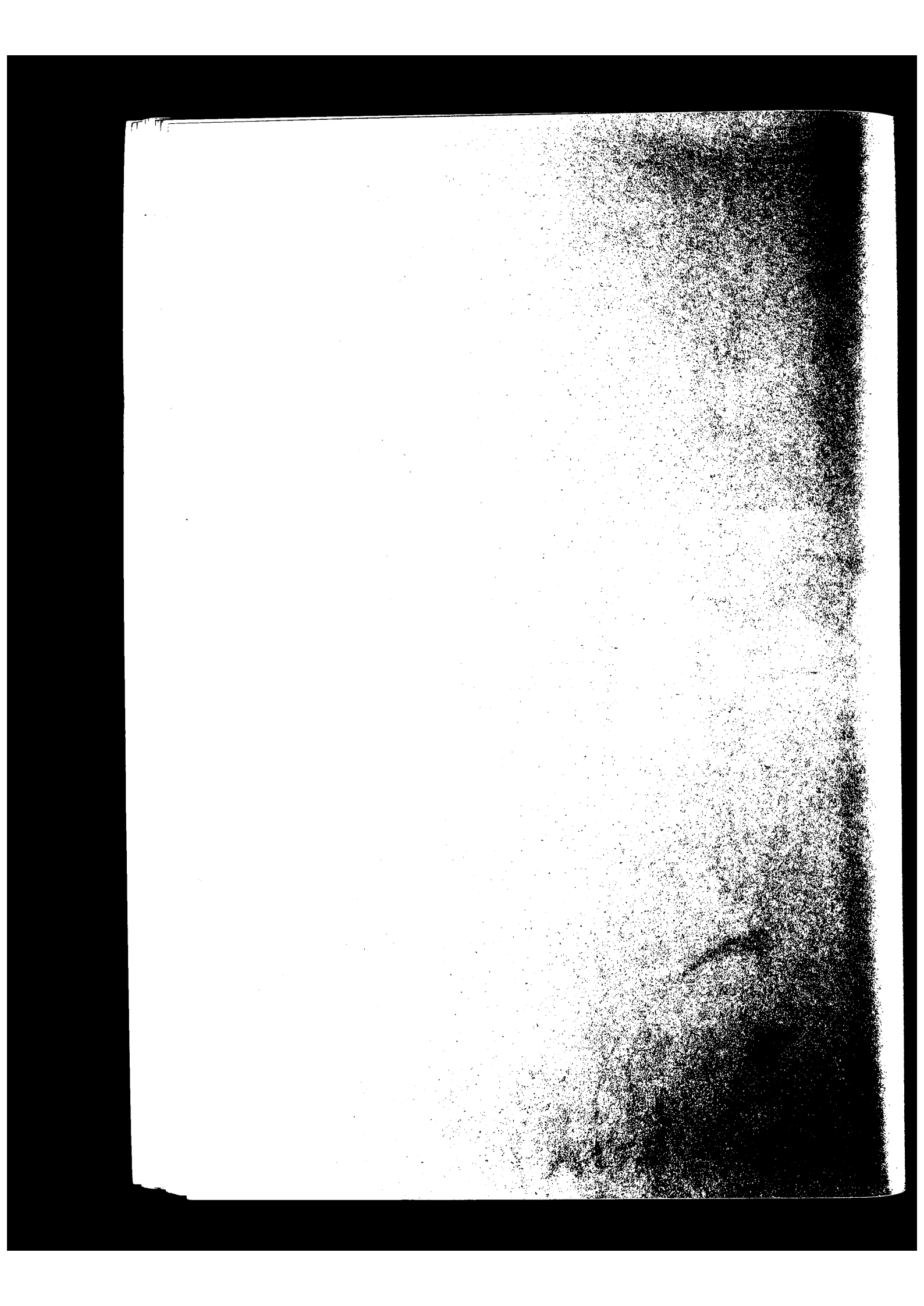
- ☑ PCTs and strategic health authorities must recognise primary care mental health services as an essential part of the range of services for people with mental health problems, alongside specialist mental health services.

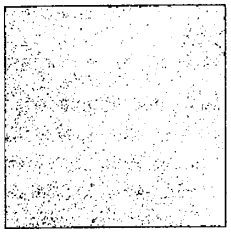
- ☑ PCTs need to identify a budget for primary care mental health services, to support the implementation of the NSF and NHS Plan targets.

6 Specialist services →

This chapter reviews specialist mental health services, in hospitals and in the wider community. In particular, it focuses on:

- developments in hospital and community services
- patient choice in treatment options
- advocacy
- how well services meet the needs of black and minority ethnic people
- variation in performance across the capital.





6 Specialist services

The previous chapter looked at the important contribution that primary care professionals make towards caring for people with mental health problems. In Chapter 8, we also consider the potential for promoting good mental health and reducing mental health problems. But realistically, even if the number of people with mental health problems is minimised and optimum care is delivered within primary care, specialist mental health services, in hospitals and in the wider community, still remain crucial to the overall picture of London's mental health. In this chapter, we look at the state of those services, with particular reference to how they have – or have not – changed in the period since 1997.

There have been a number of developments in specialist mental health services since the 1997 King's Fund report. The principle of caring for people with mental health problems in the community, to the greatest possible extent that is compatible with good care and public safety, has been widely accepted, and a range of evidence-based interventions have been established. However, these are not distributed evenly (or according to need) across the capital, and there is still an over-reliance on inpatient beds.

Inpatient beds are under great pressure, and are often occupied by people with complex needs, while alternatives to hospitalisation are still sometimes under-developed. At the same time, the pressures on acute wards have led to their being difficult places for service users and staff alike, and there are clear arguments for looking at the environment, ethos and quality of care on acute wards, at the same time as services in the community are being developed more fully.

The overall pattern of care, and the nature of the services available, affects all sections of the community, but some sections of the community are disproportionately disadvantaged by poor care. Black and minority ethnic (BME) communities and women – especially BME women – are particularly affected by an over-reliance on hospital care, as these groups often perceive this type of care as unhelpful or oppressive. Getting a clear picture of the pattern of services today, or in the recent past, is no simple matter. Unless stated otherwise, figures are based on MHI Working Paper 7 (McCrone 2003), which describes in detail how this information was collected and how reporting mechanisms have changed over time, making direct comparisons difficult. In spite of the difficulties, a reasonably clear picture has emerged for most parts of the service, although figures are less reliable in some areas.

What was the situation in 1997?

The pressures on acute wards have led to their being difficult places for service users and staff alike.

The 1997 King's Fund inquiry found very high levels of demand for mental health services, causing immense pressure within those services, gaps in care and long delays, particularly in community-based services, rehabilitation facilities and beds for those with acute problems. Groups that were particularly poorly served included children and young people, people with severe and long-term mental health problems, and black and minority ethnic groups.

The variations in what is provided in different parts of London cannot be satisfactorily explained by actual variations in socio-demographic factors, nor by day-to-day demands on services.

What has changed since 1997?

Overall, the level of service provision has increased – in London and in the rest of the country – since 1997. This was to be expected, given that after the current government was elected in 1997, it pledged to spend an extra £700 million nationally on mental health services over a three-year period. In addition, other funding has been allocated for secure care, as well as ongoing increases in general resources.

However, there are still not enough of the right sorts of services to meet Londoners' needs. London appears to be locked into using high levels of acute inpatient beds – partly because of the continuing high levels of compulsory admissions under the Mental Health Act, and the under-development of community services, including those services offering help to people in crisis. In this respect, London's balance of services looks different to that in many other parts of the country, with London having a low level of community provision compared to its levels of inpatient care. The variations in what is provided in different parts of London cannot be satisfactorily explained by actual variations in socio-demographic factors, nor by day-to-day demands on services.

The following sections provide some understanding of how mental health services have changed in quality and distribution across London since the 1997 inquiry. As we will see, the London picture is a complex mosaic, but one that shows an overall picture of over-reliance on inpatient services and under-development of community services. Within that picture, some parts shine out as beacons of excellence, while other parts lag far behind in terms of quality and appropriateness.

What has changed within hospital services since 1997?

Overall, London still has a heavy reliance on hospital beds. In particular, it commissions a high number of secure beds. These factors are widely thought to distort priorities within London's mental health services.

How has London's occupancy rate in acute inpatient beds changed?

For the first five years for which figures were available (1996–2001), London had a consistently higher rate of available and occupied beds than other regions. Acute bed occupancy rates in London have been very high for the years for which figures were available (1996–2002), and have exceeded those of all other regions.

Some of the large increases and decreases in acute beds in London may reflect planned changes that have been made with the aim of redistributing hospital places across London, thus removing some of the historical concentrations that had grown up over the years. Also, variations are to be expected in the capital, given the different levels of need of the local population. However, research undertaken for the inquiry suggests that some boroughs, such as Ealing or Richmond and Twickenham, had far fewer beds than might be expected given the nature of their local populations. At the same time, other boroughs, such as Hounslow or Waltham Forest, had many more beds than might be expected given their predicted need. There is no obvious relationship between bed supply and expenditure.

Within London, there is great variation in the numbers of acute beds and in the pressure on those beds. The highest numbers of acute beds per 100,000 people were in Camden, Hounslow and Westminster, with the lowest being Bexley, Bromley, and Richmond and Twickenham. Some areas in London have shown dramatic changes in bed numbers since 1996 (McCrone 2003, MHI Working Paper 7).

What are the pressures on acute wards?

There has been little change in the number of people admitted formally under the Mental Health Act, but London has twice as many formal admissions as any other region. The Health and Social Care Advisory Service (2003) was surprised to find that less than 50 per cent of patients in London's acute mental health wards had been detained under the Mental Health Act, although it suggests that individual trust returns may indicate a higher percentage. Anecdotally, patients and staff reported that on some inpatient wards, almost all inpatients are formal admissions, and it is virtually impossible to gain admission informally. This situation gives an indication of the pressures on staff and patients in London's acute mental health wards.

Patients formally admitted to acute wards generally go to NHS facilities. However, of those Londoners who are formally admitted under the Mental Health Act, almost one-in-eight go to private sector facilities, many of which are located out of London, away from family, friends and any other support networks.

The high level of formal admissions, and the heavy demands on the inpatient service, clearly have implications for patients, whose chances of receiving care and treatment in a calm and peaceful environment are poor. Service users participating in King's Fund discussion groups spoke of the difficulties experienced by voluntary patients in the capital's wards, where many people are detained under sections of the Mental Health Act. They felt that the wards had become frightening places, and felt that less attention was given to those who were not exhibiting very difficult behaviour.

The service users also reported that patients were sometimes unable to leave the ward for fresh air or a change of scene, because staff were too busy to make sure that voluntary patients were able to come and go when they wanted. People detained under the Mental Health Act who want to take exercise find that this is even more difficult, because staff cannot be spared to take them out. These problems take on a particular significance for the many patients who stay for long periods on an acute ward. A bed census carried out by the Health and Social Care Advisory Service (2003) reported an average stay of 15 weeks, and found that 35 per cent of patients in London's acute wards had been in hospital for three months or more.

Service users felt that the wards had become frightening places, and felt that less attention was given to those who were not exhibiting very difficult behaviour.

Service users with dual diagnosis

The high rate of people in London's with dual diagnosis (*see* Chapter 3 on the unique features of London's population) has considerable implications for inpatient services, and for other kinds of services. In their recent study of three inner-London psychiatric units, Phillips and Johnson (2003) found a high rate of dual diagnosis: 49 per cent of inpatients with psychotic illness. They note that this fits in with reports of increased bed use among individuals with dual diagnosis,

It seems difficult to prevent inpatients with drug or alcohol misuse problems from continuing to use substances while in hospital.

although it is unclear whether it is the admission rate, length of stay, or both variables that have increased.

The study also suggests that while people rarely have their first experience of drug use while on hospital premises, those who regularly use alcohol and/or drugs in the community continue to use these substances on the wards, as inpatients. Participants reported a range of substances used on the wards – including alcohol, cannabis and crack. On the inpatient wards sampled, cannabis (in particular) was readily available and widely used. Phillips and Johnson conclude that it seems difficult to prevent inpatients with drug or alcohol misuse problems from continuing to use substances while in hospital, and argue that further consideration and investigation is needed of how best to manage this group.

Moreover, in a recent Health and Social Care Advisory Service publication (HASCAS 2003), a consultant is reporting having said that in one area of London, urine and blood samples would show that 100 per cent of people on the ward had taken street drugs prior to admission – and that for many, this was a chronic problem. It is also apparent that there are worrying levels of drug-taking and drug dealing within acute inpatient facilities.

Aggression and violence

Another problem on acute wards is the level of aggression and violence, which are all too common. Many argue that the level of aggression and violence on acute wards reflects service users' substance misuse far more than their diagnosed mental health conditions. In discussions held as part of the 2003 inquiry, professional groups told the King's Fund that they believed that the incidence of substance misuse on London's acute wards had increased significantly since the previous mental health inquiry in 1997.

Above all, service users are greatly affected by the lack of calm on acute wards, and many of the pressures affect them and the staff caring for them in similar ways. Aggression and violence are deeply detrimental to service users. Although service users in the King's Fund discussion groups acknowledged the caring attitude of many ward staff, some reported aggression and violence being perpetrated by staff towards service users, as well as the other way round. On occasions, ward culture was seen as threatening.

At one discussion group, service users felt that many mental health staff were good and friendly, but that they were often too busy to talk or to respond outside times of crisis. Service users reported difficulties with getting good physical care on some acute wards – for example, in accessing dentistry. Some felt that they were seen as a 'mental health problem, and nothing more'.

> *You feel unlistened to. You feel that you are endangered by the system. The drugs you are given can have very damaging side effects. Nobody listens to you.*
>
> *[One user, speaking of her voice] It makes a sound but its not heard.*
>
> *I think it would be more therapeutic for staff... to see patients become independent and move on. Certainly amongst some of the older staff, there is almost a paternalism and an ownership of patients.*
>
> Participants, King's Fund discussion groups

Gender and diversity

Women and men alike are affected by the lack of peace and calm on acute inpatient wards, but in some respects it is worse for women. Although the provision of women-only space has improved somewhat, it is remains inadequate, and services for women with dependent children are meagre. Service users at a King's Fund discussion group spoke movingly of the difficulties experienced by women on acute wards. However, isolated examples of excellent facilities do exist in London. The Health and Social Care Advisory Service (2003) reports that a number of solutions to the real concern over women's safety have been 'suggested and operationalised'.

Issues for black and minority ethnic people using mental health services are discussed further below (p 86), but it is important to note that African-Caribbean mental health service users have expressed particular concerns about acute inpatient wards. In MHI Working Paper 5, Keating *et al* (2003) report that when acute care was discussed, African-Caribbean service users expressed high levels of fear and apprehension – even to the point of fearing death.

What is the quality of the physical environment in acute mental health wards?

Service users who took part in King's Fund discussion groups expressed a range of views about the physical condition of the ward environment. Overall, most spoke of the improved physical fabric of inpatient wards. Those who had been inpatients in the old institutions could see the difference over time. They spoke of a cleaner environment, single rooms and better food. However, in areas where there had been little investment – even when the wards were in district general hospitals or on smaller sites – the physical fabric was seen as very poor. The kinds of improvement that were most valued were the single rooms and better furniture, quiet rooms, provision for non-smokers, air conditioning, gardens and 'decent' showers, as well as improved food:

> *People have their own en suite bedrooms, which I think is a vast improvement.*
>
> *I'd say the physical environment has improved over the last 20 years. Whether attitudes have changed so quickly, I'm not so sure.*
>
> *The environment – it's nasty... You wouldn't want to go in there for long.*
>
> Participants, King's Fund discussion groups

The Health and Social Care Advisory Service (2003) discusses these observations about the physical environment of London's acute mental health wards. It remarks that many efforts have been made to improve the physical environment within old premises, and that many impressive developments in new build were evident. However, it also notes many examples of poor environment in the inpatient setting. As particular risk areas, it identified wards within acute general hospitals, and old mental health hospital wards that do not allow for changes without major disruption or expense. It also raised concerns about the lack of outdoor space.

African-Caribbean mental health service users have expressed particular concerns about acute inpatient wards.

On a positive note, HASCAS viewed the King's Fund 'Enhancing the healing environment' programme very positively. The programme has been developed to encourage and enable nurse-led teams to work in partnership with service

users to improve the environment in which care is delivered. (*See*: www.kingsfund.org.uk/grants/ enhancing_the_healing_environment.html.) Members of staff who had taken part 'were looking at their environments with fresh eyes and reflecting how they could be improved' (Health and Social Care Advisory Service 2003).

How can acute care forums help service users?

Many of the issues discussed above have been recognised and acknowledged by service users, staff and policy-makers at all levels. Department of Health guidance (Department of Health 2002h) calls for every mental health trust to set up an acute care forum, to identify strengths and weaknesses and bring about change. Each forum should undertake a service-mapping exercise, to identify in detail the baseline information required to know what is happening in inpatient services, such as how the ward works, and how staff and service users spend their time.

How effective is the procedure for discharge from acute wards?

Some service users spoke of people being discharged from acute wards before a care plan had been formulated – let alone agreed by the service user. The care programme approach (CPA) applies to everyone who is under the care of specialist mental health services, both for health and social care, and operates regardless of whether the service user is at home or in the community. Effective care planning provides 'an ongoing framework for properly assessed and co-ordinated care' (Department of Health 2002h, p 10). The CPA is not confined to planning hospital discharge, but should provide continuity for the service users, and must be developed around their needs, with their participation and agreement.

Service users also reported variability in the operation of the care programme approach (CPA). Professional groups added that given the mobility of London's population, the CPA can be difficult to maintain:

> *The bottom line is... if you are a care co-ordinator, [you need to] actually sit down with the user and say, 'Right let's plan your CPA as a first step', rather than asking the doctor 'When are you available?' and the social worker 'When are you available?', and then fixing a date. Because if you did it the other way round, people would actually invite who they want[ed] to come to their CPA.*
>
> Participant, King's Fund discussion group

In recent research, Rethink (2003) found that 52 per cent of 2,998 respondents did not know their level of care under the CPA. Almost as many (48 per cent) either did not have a care plan, or could not be sure that they had one. However, of those who did have a care plan, 90 per cent reported that their views and preferences had been considered when the plan was developed.

What is the availability of psychiatric intensive-care beds?

Psychiatric intensive care is provided for patients who are compulsorily detained, usually in secure conditions, while they are experiencing an acutely disturbed phase of a serious mental disorder. There is an associated loss of capacity for self-control, with a corresponding increase in risk, which does not enable them to be managed or treated safely and therapeutically on a general open acute ward (Department of Health 2002c).

London has consistently used more beds per 100,000 people than any other region.

Many areas in London report that they do not have intensive care beds. Among those that do, there is a large variation in provision, ranging from 3 per 100,000 in Ealing to 21 per 100,000 in Kensington and Chelsea (McCrone 2003, MHI Working Paper 7).

What are the trends in medium and low-secure beds?

All areas experienced a sharp increase in medium and low-secure bed days commissioned from NHS trusts and the independent sector. In London, the number of medium- and low-secure beds had almost doubled between 1996 and 2001, and London has consistently used more beds per 100,000 people than any other region. This is an important part of the London story, because such significant amounts of money are used for this purpose. The high demand for medium- and low-secure beds also has knock-on effects on all other parts of the system, as people who have been in medium and low-secure beds often come to need other mental health beds or community support, as well as housing.

There has been a dramatic increase in the number of secure beds used in all regions, with the absolute numbers in London being far in excess of those outside the capital, and it is not entirely clear why. It may reflect the increased attention on the need for secure beds following a number of high-profile cases, in which people with severe mental illness and dangerous behaviours were not cared for appropriately, putting them – and others – at risk.

It can be argued that government action has focused disproportionately on this small (though extremely worrying) group of people, while failing to respond adequately to the far larger challenge of people who need non-secure hospital and community-based provision.

The high use of medium- and low-secure beds may also reflect a 'supply side-effect', in which beds are used simply because they are available. The independent sector has provided a large number of beds for secure care, and it is a common economic argument that supply creates demand. In recent years, the Government has maintained this phenomenon by allocating more funds for medium-secure beds. It follows that an NHS trust that suddenly has a large number of extra beds will invariably seek to fill them.

What are the trends in long-stay beds?

In 1996/97, London had the second-highest number of long-stay beds per 100,000 population of all regions in England, but by 2001/02 the number was below that of most regions. In fact, between 1996/97 and 2001/02, the number of available long-stay beds fell by 61 per cent (McCrone 2003, MHI Working Paper 7) and the number of occupied beds has shown similar trends. This decrease reflects policy designed to enable more people with mental health problems to live in the community, with the support of services delivered in their own homes or neighbourhoods.

What is the provision of beds for children and elderly patients like?

In various regions, the number of NHS beds provided for children has declined between 1996 and 2002. However, in London, the number of beds has generally been proportionately far higher than in other regions, although it has shown

In the past five years, there has been a slow but steady growth in community services in London.

marked variation. In all regions, the number of such beds was low in comparison to the number of beds for adults of working age.

During the same period, beds for elderly patients declined in all regions. However, again, the number of beds in London was proportionately higher than other regions.

What has changed within community services since 1997?

In the past five years, there has been a slow but steady growth in community services in London. This has changed the face of mental health services in the capital, although much remains to be developed, and provision is uneven across different areas. It is rarely possible to make useful comparisons between the current situation and the level of community provision in 1997, since many of the specialised teams that are now developing barely existed – if at all – at that time.

How does London's use of residential care compare to that of other areas?

Overall, London does not have a particularly high number of residential care beds. This is not surprising, as the figures available include beds for older adults, and the average age in London is relatively low. However, compared to other regions, London has many more people with mental health problems under the age of 65 supported in residential care homes. Compared with the north west of England, London has 83 per cent more people with mental health problems under the age of 65 supported in residential care, and compared with the West Midlands and South East regions, this figure rises to 159 per cent. There has been a modest increase in these numbers over time, which is in common with most other regions.

Within London, there is a wide variation in the use of care homes by people of working age with mental health problems. In the year up to 31 March 2001, the largest numbers of under-65s supported in care homes were found in Westminster and Haringey, with the lowest numbers in Havering, and Barking and Dagenham. Westminster had 9.9 times the number of those in Havering. The amount of variation explained by socio-demographic variables was 63 per cent. Haringey, Croydon and Westminster had at least 30 more supported residents per 100,000 population than predicted, while Hounslow, Ealing and Waltham Forest had far fewer. However, these differences are not reflected in differences between actual and expected social services expenditure on adult mental health services – with the exception of Westminster.

How do community mental health teams add to the mix?

Community mental health teams (CMHTs) exist to offer adults of working age the full range of mental health treatment, monitoring and care. Most people treated by these teams have time-limited disorders, and are referred back to their GPs after a period of weeks or months, while a substantial minority will remain under their care for years. In addition to offering prompt and expert assessment of mental health problems and delivering effective, evidence-based treatments, community mental health teams should provide support and advice to primary care services.

In 2003, every local implementation team area had at least one community mental health team. London has the highest number of people per 100,000 population on CMHT caseloads. Within London, there appears to be less variation in the number of people on CMHT caseloads than there is for crisis resolution teams, although the highest (Greenwich) has around six times as many patients per 100,000 people than the lowest (Newham). Very little of this variation can be explained by differences in need among the local populations, and it is more likely to reflect different stages in setting up such teams.

How has assertive outreach been developed?

Assertive outreach is a service designed to meet the needs of the small number of people with severe mental health problems with complex needs who have difficulty in engaging with services, and often require repeat admissions to hospital. An assertive outreach approach seeks to:

- develop meaningful engagements with service users
- provide a sensitive service that is responsive to cultural, religious and gender-related needs
- support the service user and family, friends and carers
- ensure effective risk assessment and management.

Evidence suggests that the following principles of care are effective:

- a self-contained team responsible for providing the full range of interventions
- a single responsible medical officer, who is an active member of the team
- treatment provided on a long-term basis, emphasising continuity of care
- the majority of services being delivered in community
- an emphasis on maintaining contact with service users and building relationships
- care being co-ordinated by the assertive outreach team
- a small caseload of no more than 12 service users per member of staff.

Department of Health (2001c)

There are some variations across the capital in the provision of assertive outreach. In 2003, 94 per cent of local implementation team areas in the London region had assertive outreach teams. Two other regions (East Midland and Eastern) had rates of 100 per cent, while North West region's LIT areas only had 69 per cent coverage (McCrone 2003, MHI Working Paper 7).

London has the highest number of people per 100,000 of the population on assertive outreach team caseloads. Within London, the highest assertive outreach team caseloads per 100,000 were in Westminster, Lambeth and Haringey.

To what extent are crisis resolution teams available?

Crisis resolution and home treatment teams are intended to offer an alternative to inpatient care for adults of working age who are experiencing an acute psychiatric crisis.

A crisis resolution team should be able to:

- act as a gatekeeper to mental health services, rapidly assessing individuals with acute mental health problems and referring them to the most appropriate service

The patchy development of crisis teams across London is particularly worrying, as research evidence suggests that these teams have the greatest impact on admissions.

- provide immediate multi-disciplinary, community-based treatment 24 hours a day, seven days a week, for individuals with acute, severe mental health problems for whom home treatment would be appropriate
- ensure that individuals experiencing severe mental health difficulties are treated in the least restrictive environment, as close to home as clinically possible
- remain involved with the client until the crisis has resolved and the service user is linked in to ongoing care
- be actively involved in discharge planning, and provide intensive care at home to enable early discharge, if hospitalisation is necessary
- reduce service users' vulnerability to crisis, and maximise their resilience.

Department of Health (2001c)

In spite of the importance of these functions, most areas do not yet appear to have a crisis resolution service. However, it is evident that there are some problems with the available figures, as they does not always accord with local knowledge of actual service provision. In 2003, the percentage of LIT areas with crisis resolution teams in London was 34 per cent, and only the North West region had a lower percentage (McCrone 2003, MHI Working Paper 7).

The patchy development of crisis teams across London is particularly worrying, as research evidence suggests that these teams have the greatest impact on admissions. It is, therefore, not surprising that bed occupancy rates have not fallen and that in fact, they have risen slightly.

Professionals participating in the 2003 King's Fund mental health inquiry discussion groups spoke of the shortcomings of accident and emergency (A&E) departments for people experiencing a mental health crisis. The targets set for A&E were seen as unworkable for people in need of mental health assessments. In the absence of appropriate crisis resolution facilities, A&E was too often the destination for very distressed and unwell people.

What is the current situation in residential crisis services?

In addition to teams that can help people in a crisis, some London boroughs (for example, Camden and Islington, Haringey and Croydon) also have residential crisis services. These are significant because they represent an alternative to inpatient care. The Nile Centre in Hackney also offers residential crisis services for African-Caribbean men and women in the borough:

> *... Clients have found [the crisis house] so valuable... What they needed was someone to talk to, for two or three days, just to be out of the situation they were in. No specific input, just a different place, with kind staff.*
>
> Participant, King's Fund discussion group

How far does London depend on home care?

In 2003, London had the second-highest number per 100,000 population of under-65s with mental health problems who were looked after in their own home. Only Eastern region had higher numbers. In the previous two years, London's numbers per 100,000 population had exceeded all other regions.

To what extent are day care services used in London?

In 2001/02, London had the second highest rate of under-65s using local authority day-care services. However, the rate of older people using day care was the lowest in the country, along with the South West region.

There is a marked variation across London for NHS and other day care attendance, although there are also concerns about the quality of the data available.

Service users at King's Fund discussion groups expressed varying opinions about the changing nature of day services. Many day centres are no longer just places to 'sit and smoke', and service users recognised and welcomed the fact that more activities and therapies were becoming available.

Equally, however, service users pointed out the value of having a place to drop in when they were feeling unwell or feeling very alone. This seems to point to the need for a range of day centres and resource centres where focused therapeutic input and employment support are available, but where some elements of a simple drop-in service are retained. Service users spoke highly of the centres that made good connections with external activities, such as links with the local adult education college:

> *It has much more focused care. The advantage is, you're not an invisible patient.*
>
> *Since I've been off sick... I've just walked around the local town centre and I've met so many others who say 'Have you got time for a coffee?' Because they have nothing to do, they're literally walking around the shops with no income to spend, no base, no informal drop-in place where people might be welcome. It's like life hasn't picked you up again afterwards.*
>
> Participant, King's Fund discussion groups

How much choice do patients have around treatments?

In the King's Fund discussion groups, service users said they wanted to be able to make choices about the kinds of treatment they received. While none advocated a regime entirely without medication, they were deeply concerned that they should receive good information and be able to make choices. They pointed out that service users often get medication from the hospital pharmacy in a bottle or blister pack, so there is no information leaflet included, although this contravenes the requirement for pharmacists to provide a patient information leaflet with all dispensed medicine that is to be administered by a patient – be that in the community, for use on discharge from hospital, or for self administration while in hospital.

They felt that this was wrong, as people who go to their GP for other conditions get advice and information leaflets. Service users wanted alternatives to medication to be more freely available. They also wanted more psychotherapy, self-referral counselling and cognitive and behavioural therapy.

A recent survey by Rethink (Rethink 2003) produced similar results, with 76 per cent of respondents feeling that medication was helping them, but at the same

time, when asked to indicate top priorities for improving services, 34 per cent mentioning the need for medications with fewer side effects. Only 53 per cent of respondents always felt able to talk to a nurse or doctor about their medicines. Almost half (49 per cent) rated greater access to talking treatments and alternative therapies in their top three priorities:

> *I think people need to be open and honest with users, and I still think there is a reluctance to do that... [But they] know this is going to impact on compliance, and then they don't tell them the truth, or where they can go and find out.*
>
> *Talking of cognitive behavioural therapy, one user said to me 'It just seems a shame that they need to have a breakdown before they actually get access to somebody.'*
>
> *Patient-centred service – that's a lovely phrase actually. Yes, it's supposed to be a patient-centred service, and it is actually a psychiatrist-centred service.*
>
> Participants, King's Fund discussion groups

How far has advocacy become an accepted part of the mental health environment?

It is not possible to quantify the extent to which advocacy services are offered to mental health service users. Service users in the King's Fund discussion groups valued these services highly, where they existed. However, they felt that some mental health staff did not understand the role of advocates:

> *One patient said that when she first saw an advocate coming onto the ward... she felt as though she had been 'visited by an angel', because it was something independent. It was somebody not part of the life of the ward – an independent person.*
>
> *A consultant said to me once, 'I came into this job to advocate for mentally ill people. Why do they need [a separate] advocate?' And she couldn't see how a patient might need some independent thought.*
>
> Participants, King's Fund discussion groups

How well do mental health services meet the needs of black and minority ethnic people?

Nowhere is the inequality in levels of service more evident than in relation to mental health services for black and minority ethnic people. Concerns about the shortcomings of mental health services in relation to the needs and experiences of black and minority ethnic people have been expressed for a very long time, and were discussed at length in the 1997 report (Johnson *et al* 1997, pp 143–66).

What was the situation in 1997?

The 1997 report drew attention to:

- London's ethnic diversity
- the lack of confidence by BME communities in psychiatric services, coupled with a tendency for black Caribbeans to enter the services via the criminal justice system or compulsory admission

Nowhere is the inequality in levels of service more evident than in relation to mental health services for black and minority ethnic people.

- the limited cultural competence of professionals in statutory mental health services
- services that were not seen as acceptable by BME communities
- some successful models of good practice, but mostly having insecure funding and limited links with statutory services.

What has changed since 1997?

Five years on, in terms of ethnic diversity, London is at least as diverse as it ever was, and the need for culturally appropriate services that are trusted by all sections of the population is paramount. There are still shining examples of good practice, both by individuals and by particular projects and services, but regrettably, overall, mental health services in London (and elsewhere in the country) fall far short of what is needed in a modern multi-ethnic city.

The picture of mental health services falling short of what is required and failing to meet the needs of black and minority ethnic people is all too well known, so it is not repeated here. However, it is important to note the extent to which the concerns noted in the 1997 report are still current. Issues of concern are highlighted by service users in the King's Fund discussion groups, by MHI Working Paper 5, on diversity (Keating *et al* 2003), and by other literature. An African-Caribbean voluntary organisation stated that it was so difficult to get appropriate help that families sometimes hoped their relatives would have to go to court as a way of getting support for a mental health or substance misuse problem. This view sits side-by-side with serious concerns that black men still make up a disproportionate number of inpatients, and occupy a disproportionate number of secure beds.

Separate versus integrated provision

Service users participating in the King's Fund discussions reached a range of conclusions about the benefits of separate or integrated provision for black and minority ethnic services. On the whole, they felt that there was a need for some separate provision, but that mainstream services must become more sensitive to the needs of people from black and minority ethnic communities:

> *If black people weren't accessing the day centres, for whatever reason, then those day centres need to encourage black people to go to those services.*
>
> *I think the separate black user forum is good.*
>
> Participants, King's Fund discussion groups

Recent findings

In 2002, the Sainsbury Centre for Mental Health published a review of the relationship between mental health services and African-Caribbean communities (Keating *et al* 2002). The key findings from this research were as follows:

- There are 'circles of fear' that stop black people engaging with services.
- Mainstream services are experienced as inhumane, unhelpful and inappropriate.

- The care pathways of black people are problematic, and influence the nature and outcome of treatment and the willingness of these communities to engage with mainstream services.
- Primary care involvement is limited, and community-based crisis care is lacking.
- Acute care is perceived negatively, and does not aid recovery.
- There is a divergence in professional and lay discourse on mental illness/distress.
- Service-user, family and carer involvement is lacking.
- Conflict between professionals and service users is not always addressed in the most beneficial way.
- Black-led community initiatives are not valued.
- Stigma and social inclusion are important dimensions of the lives of service users.

An important update on the situation relating to diversity and mental health services can be found in MHI Working Paper 5 (Keating *et al* 2003). This paper took a broad look at diversity, and included a review of issues facing the whole range of BME communities, as well as relevant recent developments. It also looked at gender issues for BME communities in relation to mental health services.

Keating *et al* noted that in the past five years, race equality had been prominent in policy developments at a national level. However, they also cited evidence that the issue was not accorded sufficient priority at local levels. They state that some of the new initiatives and opportunities are not sustained over time, noting the new structures that have emerged to provide greater opportunities for partnership and consultation with BME communities (including health action zones and local implementation teams).

The working paper also confirmed that acute care remains an area of concern for BME communities because of restrictive treatment regimes. At worst, some black people fear for their lives if they come into contact with psychiatric services. The document also points to high levels of unmet need among refugees and asylum seekers, compounded by staff being inadequately equipped to assess these needs.

The report raises many important issues about the continuing marginalisation of BME voluntary-sector organisations, including those working with women, refugees and asylum seekers. BME women with mental health problems are seen to experience particular problems, and continue to be marginalised and to be viewed in stereotypical ethnic images. Many BME women only access services at crisis point. This is attributed to their experiences of mental health services as inappropriate, their lack of confidence in the services, and an inadequate knowledge of what is available.

Recommendations for change

The paper's authors make a number of recommendations for change. They call for an urgent, systematic review of the inpatient care provided for BME communities in the country as a whole, and in specific local communities. The recommendations also encompass improvements needed to enhance the

BME mental health must be seen as 'core business' for all PCTs, mental health trusts and local authorities.

capacity of the BME voluntary sector, and of groups for service users, families and carers. They also call for engagement with local communities as a priority area for service development. They argue that all aspects of BME mental health must be seen as 'core business' for all PCTs, mental health trusts and local authorities, rather than as 'add-on' activities, as has historically been more common.

Since the concerns about, and dissatisfaction with, mental health services for BME people are well known, and since positive change has been piecemeal and inadequate, these recommendations are of enormous importance if we are to avoid the prospect of revisiting the issues in another few years, only to find that the old familiar problems are still in evidence:

> *There is still an over-representation of black people in the mental health system. There is still an over-representation of them being diagnosed as schizophrenic. There is still a failure of the system to provide services for black people who are depressed.*
>
> *At the end of the day, what all people want is to be treated as human beings – to be treated with care. And obviously, sadly we live in a society that sometimes sees colour first [and at] other times sees your 'madness' first (as they would call it), and so both discriminations come in.*
>
> Participants, King's Fund discussion groups

How far does performance vary?

In its recently published performance indicators for mental health trusts, the Commission for Health Improvement (2003b) looked at a limited number of factors in order to reach an assessment of performance.

These were:

- assertive outreach team implementation
- community mental health team integration
- mental health minimum dataset implementation
- number of outpatients waiting longer than the standard
- Improving Working Lives
- hospital cleanliness
- financial management.

The Government sees these indicators as very important in driving up standards, although many would argue that they are too limited in their scope to provide a full picture of performance in mental health trusts. Nevertheless, it is interesting to note that of the ten mental health trusts in London, three were awarded one star, five were awarded two stars and two were awarded three. (The Tavistock and Portman NHS Trust, which offers specialist mental health services, was awarded two.) These star ratings are broadly in line with national figures for mental health and learning disability trusts, although there were three zero-star mental health/learning disability trusts nationally.

Challenges

London still has a long way to go in developing the services that service users and professionals generally agree would be more appropriate to meet the needs of London's diverse population. Among other approaches, this will require new ways of working with voluntary sector organisations, and a degree of commitment to change that surpasses even the developments that have taken place since 1997.

A particular challenge is the level of violence and aggression on acute wards. In addition to the negative impact this has on service users, as demonstrated in Chapter 10, these factors have major implications for inpatient ward staff, whose workload is exceedingly complex and demanding. The pressures for staff are clearly much greater in London than elsewhere, and call for radical solutions to tackle these problems. The patchy development of crisis teams across London is another factor needing urgent attention.

Finally, to the extent that the speculation is correct, the question of the 'supply side-effect', in which the more beds are available, the more are used, provides lessons not only for the mental health field, but also for other areas of the NHS, where the independent sector may have a large stake. In mental health and in other health services, robust means must be found to ensure that service provision meets need, rather than appearing to create it.

Conclusions

There have been a number of significant and positive changes to mental health services since the last King's Fund mental health inquiry. The development of community mental health teams is almost universally regarded as a major step in the right direction. Assertive outreach, early intervention and crisis resolution services are also having a positive impact. The concerns that remain about community-based services are mostly about the uneven development of these services across London, and the extent to which they fall short of meeting need in parts of London.

However, important concerns remain about how mental health is viewed and understood by the public, and – perhaps even more importantly – by politicians and policy-makers. A disproportionate emphasis on dangerousness and risk has focused attention on the development of secure services. This has inevitably directed the focus away from the continuing development of much-needed community services. It may also have diverted attention from developing mental health services in primary care, and from thinking about improving the care given in acute inpatient units to people with severe mental illness whose condition does not pose a threat to others or require secure facilities.

Important concerns remain about how mental health is viewed and understood by the public, and – perhaps even more importantly – by politicians and policy-makers.

Much has improved, but the balance of care in London is not yet right, and both community-based and hospital-based services stand in need of development.

Acute wards seem to have suffered from a degree of neglect since 1997, despite some improvements to the physical environment. They are often seen as unsafe and unattractive, by service users and staff alike. There remains a need to address violence and aggression on the wards, and to get to grips with the challenges

There are many indications that community teams gain at the expense of acute wards.

posed in London by the very high numbers of people who have a substance misuse problem as well as a mental health problem.

There are many indications that community teams gain at the expense of acute wards: acquiring their most experienced and competent staff, and leaving behind a relatively low proportion of experienced and permanent staff whose numbers are augmented by temporary and less experienced staff. At the same time, the demands made on acute-ward staff have grown, with the increase of dual diagnosis and the higher dependency levels of people who cannot be treated in the community.

London's mental health services have yet to achieve a good enough standard of appropriate and acceptable mental health services for black and minority ethnic communities. In spite of a growing number of examples of excellent and sensitive services, the overall perception of mental health services by black and minority ethnic people has scarcely improved since 1997. Black people are still over-represented as users of mental health services – particularly in inpatient wards, including secure facilities. Often, they see those services as frightening and inappropriate. These problems are well recognised, but solutions remain to be put in place.

Appropriate provision for women also needs further development. All of these issues for black and minority ethnic people, and for women, can be taken forward in the context of improving patient choice.

The contribution of mental health service users to improving services is very significant – and could be even more so, if mental health service users and their organisations were adequately supported and funded.

Other concerns that were mentioned in the course of this inquiry but were not the subject of detailed exploration included mental health services in London's accident and emergency units, and the mental health of prisoners. More work needs to be undertaken on both these issues.

In addition, questions about performance management have arisen during the course of this inquiry. As we have seen in Chapter 4, strategic health authorities do not appear to be effectively managing performance, and the performance of providers and commissioners does not appear to be being monitored very closely. Providers and commissioners are not being called to account for the gaps and underdevelopment of mental health services in their areas, and nor is strong pressure being applied to improve performance in order to meet standards laid down in the NSF and NHS Plan targets.

Recommendations

- ☑ Mental health trusts and PCTs in London, together with their local authority partners, need to further develop community service across London, focusing especially on services for which there is good evidence of effectiveness.

- ☑ Mental health trusts need to review conditions, staffing levels and skill mix in acute inpatient wards, instigating measures to improve the status, rewards and

support for ward staff, and to improve the ethos of acute wards for the benefit of staff and service users alike. This is especially important where the incidence of co-morbidity and dual diagnosis among service users makes providing safe and effective services most challenging.

- ☑ Mental health trusts must prioritise training on dual diagnosis and complex needs for staff in London's acute inpatient wards.

- ☑ To complement local work on improving acute care, central government should commission an independent, systematic review of acute inpatient care provided for black and minority ethnic service users, to address concerns about safety and appropriateness.

- ☑ Mental health trusts and PCTs, in co-operation with their local authority partners, need to take urgent action to commission and provide a range of services to meet specific needs of black and minority ethnic service users, especially women.

- ☑ Mental health trusts, PCTs and their local authority partners should work closely with service users and carers and their organisations, which must be empowered to play a major part in making change happen. Their progress in doing so should be scrutinised by the Commission for Healthcare Audit and Inspection (CHAI) in the course of its reviews.

- ☑ Mental health trusts need to extend opportunities for shared learning between acute inpatient staff, staff in community mental health teams, and staff in assertive outreach and crisis services.

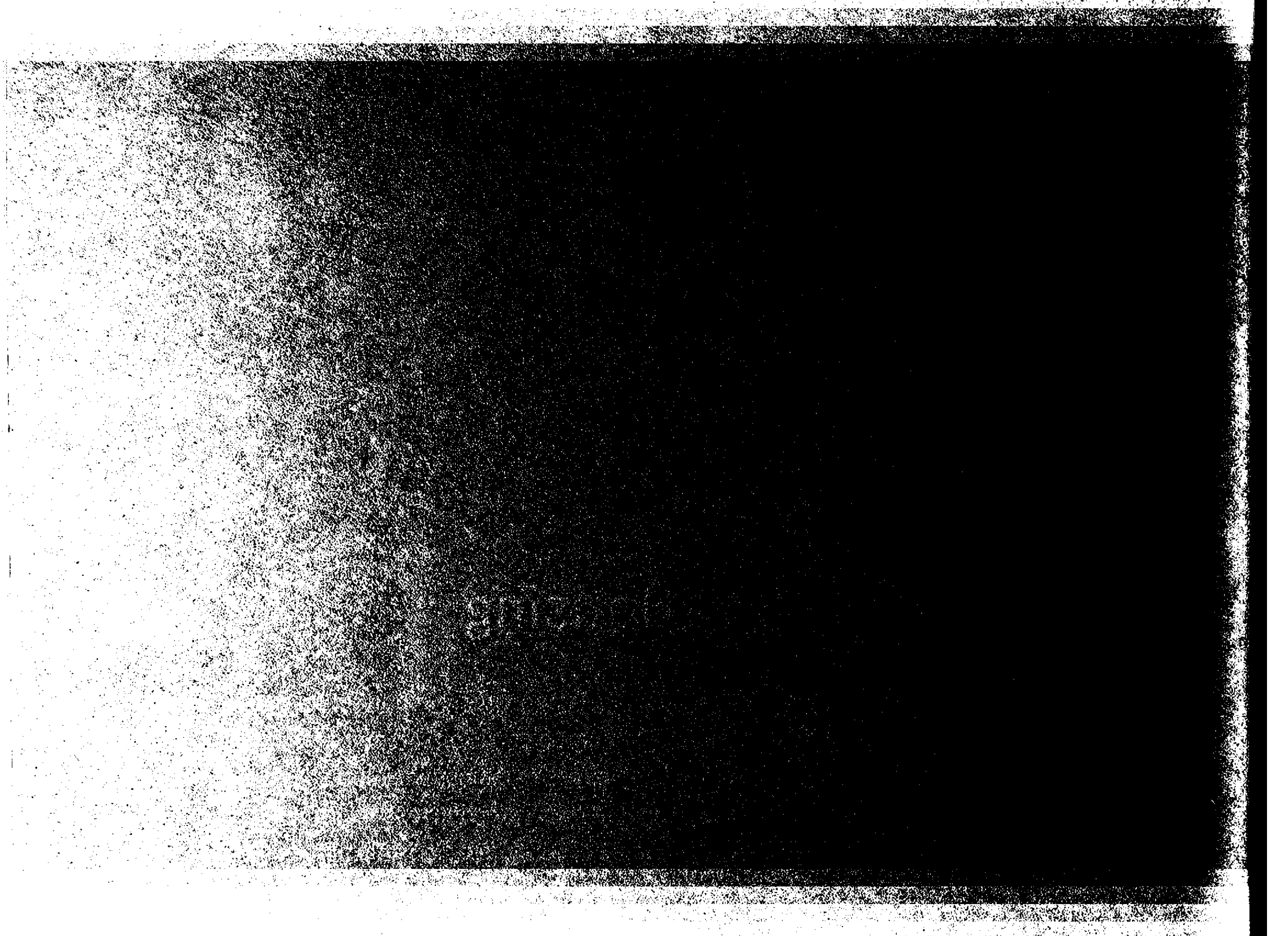
- ☑ The appropriate royal colleges, workforce development confederations (and strategic health authorities, when they assume responsibility for the work of workforce development confederations in 2004), and other bodies responsible for the education and training of primary care professionals, must ensure that primary care professionals are better trained, resourced and supported, to offer high quality care to people with mental health problems. This should include those with less serious mental health problems who use primary care but are often seen as less of a priority by specialist services.

- ☑ Strategic health authorities need to strengthen their performance management of mental health services in London, with an emphasis in achieving equity in relation to need in services across London in the context of a London mental health strategy.

7 Housing

Good housing is particularly important for people with mental health problems. This chapter examines:

- levels of access to mainstream and supported housing, and its spread across the capital
- the supply of supported housing, and its effectiveness for meeting complex needs
- the specific needs of women and black and minority ethnic groups
- whether the housing available meets today's living standards
- the impact of Supporting People.



7 Housing

Today, there are many gaps in the provision of housing for people with mental health problems that need to be addressed. The supply of modern, suitable housing with appropriate support has declined, and is unevenly spread throughout London. At the same time, expectations are rising – quite reasonably – as people with mental health problems and their organisations articulate the need for decent and affordable housing.

Added to all this, there is considerable evidence of an increasingly complex needs profile, with high levels of complex need and dual diagnoses that present major challenges to providers. Government policy at a national level (such as Supporting People) and at a London level (including the Mayor's concern to increase the amount of affordable housing in London) are all laudable, but to date they have only scratched the surface.

At the same time, there are many models of good practice that address the needs of mental health service users, and of housing schemes that have proved particularly successful in meeting the needs of specific black and minority ethnic (BME) groups.

For its investigation into housing, the 2003 King's Fund mental health inquiry, commissioned MHI Working Paper 3 (Boyle and Jenkins 2003). This chapter draws from some of the findings of that paper, from other published sources, and from the King's Fund discussion groups, to highlight the main issues that must be faced for the future in the field of housing for people with mental health needs. The equally important issue of housing for the mental health workforce in London is referred to in Chapter 10, on workforce issues. However, some of the same challenges apply to meeting both these types of housing need.

What was the situation in 1997?

In the 1990s, housing for people with mental health problems was a major issue – and remains so today. However, the common concerns about housing for people with mental health problems were a little different then. In 1997, much of the thinking about providing accommodation for people with mental health problems was heavily influenced by the recent closure of long-stay hospitals and the 'reprovision' of care that had previously been delivered in hospital.

The supply of modern, suitable housing with appropriate support has declined, and is unevenly spread throughout London.

A large proportion of post-hospital support was geared to the needs of people who had been in hospital for a considerable time, and whose experience of non-institutional life was often remote. Many of them lost their accommodation during a prolonged period of hospitalisation. Housing to meet their needs after the long-stay hospitals closed was funded through capital programmes linked to the hospital closures, and consisted largely of small group homes, rather than individual or family housing units.

In the 1997 King's Fund report, accounts of supported tenancies were presented as rather new and somewhat exceptional. Staffed hostels and other communal facilities were more common, and the needs of newer patients who were not accustomed to communal living received rather less attention (Johnson *et al* 1997). The 1997 report also describes eloquently the needs of homeless people with mental health problems. While the needs of this vulnerable group are essentially unchanged, the policy and social context within which those needs are (or are not) met has changed considerably.

What has changed since 1997?

In 2003, housing remains a major concern – not only because it has such a crucial effect on the quality of life of people with mental health problems, but also because a lack of suitable housing can delay, or even prevent, people who have used inpatient services from being discharged from hospital.

Since 1997, the range of problems and potential solutions has moved on. The profile of people leaving hospital has changed – as have people's expectations. Today, people with severe mental health problems generally experience only some of their care within inpatient services, and the duration of inpatient stays has reduced steadily. Specialist services in the community are expected to meet many of service users' needs, and while some of these services will have 'beds', others offer support based around people's own homes – for those who have homes to go to.

The housing needs of people with mental health problems are broad and complex. Some people require high levels of support for long periods, or intermittently, if they experience severe problems. Others need a lesser degree of support. Some simply require housing so they can leave hospital, and some will have housing of their own to return to. Some people with mental health-related housing needs may have spent little or no time in hospital, being supported as required, in their own homes, by primary care and community services.

A significant number of people with mental health problems are either homeless at the outset of their mental health problems, or become homeless during their course. A smaller, but still significant, proportion may experience problems with their behaviour or relationships with other people that affect the stability of their housing situation. The spectrum of need is large, and many shortcomings still remain in responding to these various needs. At the same time, expectations have changed greatly, and most people with mental health problems aspire to secure tenure in ordinary housing – with or without ongoing support.

The impact of the 'right to buy' scheme and the cost of buying or privately renting property in London combine to make it difficult for people to find affordable housing in London generally.

How has access to mainstream housing for people with mental health problems changed?

Despite the changes to homelessness legislation, access to mainstream housing in private and social sectors alike is shrinking. The impact of the 'right to buy' scheme and the cost of buying or privately renting property in London combine to make it difficult for people to find affordable housing in London generally. This is all the more so for people with mental health problems, who are often at the lower end of the income scale.

Overall, the supply of specialist housing is inadequate, the range of housing options is poor, and the quality of the housing available is variable.

How has the supply of supported housing for people with mental health problems changed?

The situation regarding supported housing is also a matter of concern. During the past five years, the working-age population has grown by 6 per cent. During the same period, the volume of specialist housing provided by housing associations for Londoners with mental health needs has remained static. In effect, this means that the supply of supported housing has declined per capita. No comparable information is available on how the supply of non-housing association provision has changed in the past five years.

During recent years, there has been some refocusing of the housing supply. There are 10 per cent more housing association-owned mental health schemes today than there were five years ago, but these tend to be smaller than the earlier ones, so that the number of units of housing has actually only increased by 0.1 per cent. The focus has changed to provide more self-contained housing, but progress has been slow, with the proportion of shared housing falling from 64.6 to 60.8 per cent.

Another worrying trend is that the number of places available for letting within specialist housing has fallen sharply (by 26 per cent in five years), as the average length of occupancy has risen. This results from two factors:

- The needs of those occupying specialist housing have increased.
- Move-on accommodation (permanent, ordinary housing) has become more difficult to access because there has been a decline in the capital's social housing of some 50,000 houses, and the cost of owner occupation or private renting is high.

Delays in getting supported housing are fairly commonplace. In one study (Greater London Authority 2003), interviews and focus groups with 28 residents revealed that 11 people had waited between six weeks and six months to be allocated their present housing, while 16 had waited between one and five years.

Is the supply of housing located equitably, and in accordance with need?

The supply of specialist housing is largely concentrated within the inner-London boroughs, reflecting the scale of local need in the inner-city areas. However, outer-London boroughs have significant needs for specialist housing too. A number of outer-London boroughs have an under-supply of community-based provision, particularly those that are not part of a former hospital closure/re-provision programme. This can result in inequitable provision, and the chances of obtaining suitable housing may depend on what is available in the area where a person comes from, rather than on the extent of their needs.

Overall, the supply of specialist housing is inadequate, the range of housing options is poor, and the quality of the housing available is variable. Much of what is available is of a poor quality.

Does supported housing offer an adequate service for people with complex needs?

Today's supported and generalist provision is housing people with more complex needs than those who were housed five years ago. Tenants are more likely to have a dual diagnosis. There is no evidence that funding, staffing or training have kept pace with this increase in the complexity of need, and there appears to be little recognition in strategic documents of how the client group has changed, or whether the existing housing and support models remain appropriate (Boyle and Jenkins 2003, MHI Working Paper 3).

Although the complexity of need has increased generally, providers of supported housing are reluctant to accept the most complex and difficult clients. This means that for those experiencing severe and enduring mental health problems – particularly those with dual diagnosis – finding housing with support remains difficult.

A recent report from the Greater London Authority, Association of London Government, Advocacy Really Works, and the Sainsbury Centre for Mental Health (Greater London Authority 2003) draws attention to the shortage of suitable support and accommodation for people moving on from secure hospital accommodation, and adds that this is likely to remain a serious challenge to services.

The report cited supported housing projects that reported receiving an increasing number of referrals for people with complex needs. They said they were experiencing particular problems in providing suitable accommodation for people with dual diagnosis, such as mental health needs and drug or alcohol problems. The report also identified gaps in provision for people with specific diagnoses or needs, especially:

- forensic history
- complex needs and high risk
- brain injury
- young people with psychosis needing early intervention.

Are specific needs being met – for example, for women, or for people from black and minority ethnic communities?

Some new models of housing provision have been developed, albeit in limited numbers. Examples include:

- successful schemes to provide alternatives to hospital admission
- women-only housing
- specific schemes for people from black and minority ethnic groups.

Looking in more detail at schemes for women, we find that supply issues apply to gender-specific schemes across all ethnic groups. From the partial data available, it appears that few areas within London have adequate provision for women – particularly for women whose cultural and religious beliefs would prevent them from sharing accommodation with men. However, some boroughs have successfully developed schemes of this type – for example, Tower Hamlets has specific provision for women of Asian origin.

Housing schemes for BME people with mental health problems remain under-developed in many areas.

Gender-specific schemes are limited, and few schemes are able to offer support for women with children. Boyle and Jenkins identified only two schemes in London that could support clients with their children, one of which provides short-term housing for crisis resolution (Boyle and Jenkins 2003, MHI Working Paper 3).

Housing schemes for BME people with mental health problems remain under-developed in many areas. However, there are interesting initiatives in some parts of the capital. One BME group has been established as part of the Supporting People planning process, with Southwark, Lewisham and Lambeth councils working in partnership to provide a wide-ranging, cross-boundary approach, and to give BME groups more visibility – especially for groups that are transient or small in numbers. Southwark Council contracts with Ujima Housing Association to provide ten places for young black men. Other local projects that are open to all have a very high proportion of tenants from minority ethnic groups – up to 90 per cent in some schemes.

In east London, the Kush Housing Association works predominantly with African-Caribbean and black British communities. Kush has developed the Nile Centre in Hackney, which provides crisis resolution for black people who would otherwise need acute provision. It is also a resource centre for non-residential services, and provides support for black people living in the area. As yet, most areas of London do not have a comparable resource, even where there are substantial BME communities.

Is the nature and quality of supported housing for people with mental health problems appropriate for the 21st century?

As noted above, much of the specialist accommodation provided after the closure of the large hospitals such as Friern and Claybury was provided in small group homes. Although it was immensely successful in enabling individuals to live in the community, new residents now regard the quality and style of this provision as poor and unattractive. Most people with mental health problems aspire to the same kinds of housing as everyone else – that is, self-contained housing of a reasonable level of comfort and security, at an affordable price.

A recent report (Greater London Authority 2003) found that changes in clientele and support provision meant that some projects were providing services within outmoded physical structures. Various factors limited the ability of projects to change to meet the needs of people with mental health problems in supported housing in 2003. These included cost, planning problems and the unsuitability of some premises for alteration.

London has a great to deal to learn from other cities such as New York, where Common Ground has been highly successful in creating mixed communities that provide affordable accommodation for formerly homeless people (including people with mental health needs), and for low-paid key workers. The accommodation is combined with services and support designed to help vulnerable tenants sustain tenancies, secure jobs and build better, healthier lives. The Common Ground schemes make key contributions to the revitalisation of the neighbourhoods of which they form part, and the health and well being of the

wider urban community. The relevance of the Common Ground concept to London is striking. The King's Fund is working in partnership with the homelessness charity Crisis to develop a scheme like this, known as the Urban Village Project, in London.

Choice of housing is another important factor. In March 2001, the Department of Transport, Local Government and the Regions (2001) announced a pilot scheme to offer tenants more choice in social housing. The idea to test choice-based approaches to lettings was originally proposed in the Housing Green Paper in 2000 (Office of the Deputy Prime Minister 2000b). While this approach has been well supported, it is important to monitor the impact that it may have on people with mental health problems, as there is a risk that it will make access to secure, social housing more difficult, rather than less so, for those who are least able to advocate on their own behalf, or to gain access to support in making their choices known.

How has Supporting People affected housing?

Supporting People is a major government policy that will fundamentally affect the future of housing for people with mental health problems. The aim of the initiative is to deliver high quality, strategically planned housing-related services that are cost effective and reliable, and complement existing care services. The planning and development of services is intended to be needs-led.

Local authorities took on the responsibility for funding, planning and commissioning all housing-related support services on 1 April 2003, when one single Supporting People grant replaced various funding schemes, including elements of transitional housing benefit, supported housing management grant, probation accommodation grant, income support and jobseekers allowance.

The old system for providing support services before Supporting People came into being was hampered by overlapping and complex funding streams, and did not meet the support needs of vulnerable people. There was little focus on the quality of service provided, and no structure to ensure that money was spent on individual needs. Also, services were more easily available to people in certain types of housing, whereas people may have needs for support wherever they live – for example, in a housing and support scheme, in a hostel, or in general housing – whether they are owner-occupiers or tenants.

In preparation for Supporting People, local authorities were required to map local support services, identify service users' needs and identify gaps in provision. That in itself has been an important step forward, although far more remains to be done. Boyle and Jenkins point out that the new policy will greatly improve the co-ordination of planning, funding, and monitoring of the sector (Boyle and Jenkins 2003, MHI Working Paper 3). It will also bring risks to providers, since funding will be less secure, and to commissioners, especially where services are not within their own geographical boundary. Its success will depend on whether it is adequately funded and thought through.

Boyle and Jenkins indicate that current housing and support priorities within health and housing agencies are focused in two areas:

- services for people with complex needs, including dual diagnosis
- services offering support to people in their own homes (usually known as 'floating support' services).

Increasing numbers of people now receive floating support, and it is inaccurate to call this 'supported housing'. It may be more appropriate in future to refer to 'housing support services', some of which may be located in supported housing, and some in other kinds of accommodation.

It is early days for Supporting People, and there is still uneven provision from area to area, but the partnership opportunities that it presents to use funds to provide integrated housing and support are a significant development.

Challenges

At best, the overall picture appears to be one of commissioners and providers having to run very fast in order to stand still, while people with mental health problems still do not obtain housing that meets their needs.

The lack of one single database of mental health provision that incorporates the new Supporting People database, registered care and other health and social services provision needs to be remedied. There is a need to develop strategic assessments of local needs, taking into account shortfalls in provision and shortcomings of existing accommodation and service models. There is certainly a need to develop and improve partnerships between health, social care and housing agencies – particularly local authority housing departments. This would go some way to address the challenges of improving access to ordinary housing, and would help provide better services, in order to prevent unnecessary homelessness through tenancy failures.

MHI Working Paper 3 (Boyle and Jenkins 2003) makes a number of detailed and practical recommendations, which provide an excellent agenda for action. The recent report by the GLA also makes a number of important recommendations that support the need for a London-wide strategy (Greater London Authority 2003).

Like the King's Fund's research, the GLA report notes the need for accurate mapping of met and unmet need. It also emphasises some important points about London's unique requirements for mental health services, and states that these should be reflected in central government funding allocations. It also underlines the need to take forward the Mayor of London's plans for 23,000 extra homes, of which 50 per cent must be 'affordable' (Greater London Authority 2002), and argues that the requirements of people with mental health needs should be considered in the planning of these homes.

It is early days for Supporting People, but the partnership opportunities that it presents to use funds to provide integrated housing and support are a significant development.

The many challenges relating to housing for Londoners with mental health problems have one thing in common: they cannot be addressed in a single-borough or piecemeal fashion. Some of the issues can best be taken forward on a national basis, but some are particularly focused on London itself, and require a whole-city approach, either instead of, or as well as, a nationwide approach. That is not to say that local communication and partnerships are unimportant – this is clearly not so. But local efforts are sometimes insufficient to enable solutions to difficult problems to be found and implemented.

Of all the issues facing people with mental health problems, the need for housing is one of the most fundamental.

Another benefit of a London-wide approach is that, as we have seen, while examples of good practice do exist, they tend to be isolated. Health and social care services have historically been beset by a culture of localised innovation, without wide dissemination of good ideas. Housing for people with mental health problems appears to suffer the same fate, although there is so much scope to learn from others. For example, individual schemes and innovative, culturally sensitive services may need to be adapted to meet varying local needs, but the wheel does not need to be reinvented every time a new vehicle is designed. The whole of London can benefit from innovations that have been tested in smaller areas of the capital.

Local work will remain important to ascertain needs, ensure dialogue between service users, commissioners/funders and providers of housing and support. However, a local approach on its own cannot address the major underlying issues, such as shortages of supply. Nor can a wholly local approach facilitate linkages in thinking about related problems, such as housing for service users and housing for the mental health workforce, which are essentially similar in many parts of the capital.

There is room for debate about how best to ensure local accountability and sensitivity to local needs, while engaging in strategic thinking for the whole of London. However, there is little doubt that improved housing for people with mental health problems in London can only be delivered effectively if there is a London-wide approach to finding solutions, backed by central government.

Conclusions

Of all the issues facing people with mental health problems, the need for housing is one of the most fundamental. For some people, it is simply a matter of housing need. Others require varying levels of support, as well as housing, in order to live as full a life as possible. This may include receiving help in maintaining their housing tenure.

The period since the 1997 report has been one of change, particularly in that the wishes and preferences of people who have developed mental health problems during the past few years are different from those of an earlier generation. The enormous challenge of resettling long-stay patients from the old institutions is now receding into history. In the 21st century, people with mental health problems are more usually treated in the community, and when they require hospitalisation, the emphasis is on returning them to the community as soon as possible.

This means that the biggest areas of need are for ordinary housing, and for housing with some support services offered. People naturally want their own front door rather than group homes, and they do not necessarily wish to live in a specialised facility in order to access support. People also want continuity and security in housing and support. Hostels that require people to move on do not offer that, and although they meet the needs of some people very well, most people would probably prefer more permanent housing with varying levels of support that increases or decreases as necessary.

At the same time, some of the needs of Londoners are becoming ever-more complex. Those with alcohol or substance misuse problems in addition to their

mental health problems – widely thought to be an increasing number – may need a high level of support, and may find it difficult to maintain tenancies.

The provision of social housing is very important for people with mental health-related needs, but overall there has been a slight decline in provision relative to the needs of the population, and there are great variations in provision across London.

The development of the Supporting People programme is welcome and positive, but much remains to be done to agree provider priorities in offering specialist accommodation and appropriate support, and to ensure that funding from Supporting People, health and social services is co-ordinated, and is sufficient.

In spite of all the information that is available, there are gaps in information, and there is a great need of a London-wide approach to data collection.

Recommendations

- ☑ Local authorities, in co-operation with PCTs, need to undertake strategic assessments of local needs, taking into account shortfalls in provision and shortcomings of existing accommodation and service models, as well as the needs of people with dual diagnosis and complex needs.

- ☑ Local authorities and other housing providers must work with black and minority ethnic communities and agencies to develop models of good practice in meeting the housing needs of mental health service users from those groups, across London.

- ☑ The Department of Health and the Office of the Deputy Prime Minister (ODPM) should work together to introduce a single database of mental health provision in London incorporating the new Supporting People database, registered care, and other health and social services provision. This should be used to develop mental health and housing strategies to feed into future Supporting People planning.

- ☑ The ODPM must work with key London-wide statutory and voluntary organisations to agree an action plan for housing for people with mental health needs in London. This would include ordinary, permanent housing for people with mental health needs.

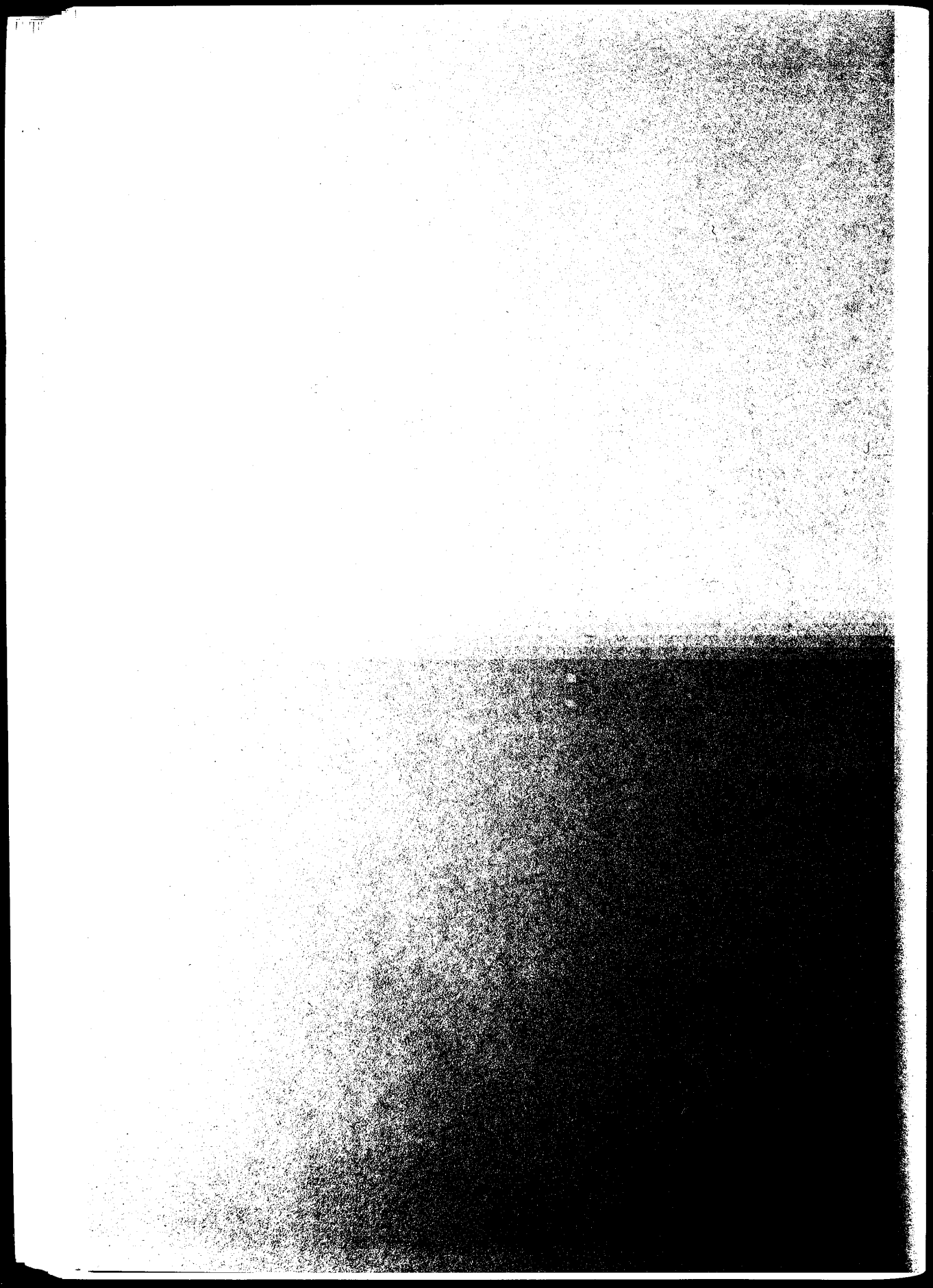
- ☑ Local authorities and housing providers need to do more work on ways to help mental health service users find and keep suitable housing. The Social Exclusion Unit could usefully consider housing for mental health service users as a factor affecting employment in its forthcoming work on mental health and social exclusion.

- ☑ The Housing Corporation, housing associations and Supporting People teams should publish models of good-practice approach that combine the provision of housing and support for people with mental health needs with affordable housing for key workers.

8 Mental health promotion →

This chapter focuses on the issue of promoting good mental health, and asks how the situation has changed since the first King's Fund mental health inquiry in 1997. It:

- outlines the policy context for mental health promotion
- addresses the question of why this proactive approach to mental health has a relatively low profile.



8 Mental health promotion

Tackling the root causes of social problems that can exacerbate mental health problems is a very important task, but the will to do so is not always apparent. Few people would suggest that promoting better mental health would actually prevent the occurrence of the most severe mental health problems – although who can say what impact a public health approach to good mental health could have on the mental health of the population overall?

However, a positive approach to reducing mental health difficulties and promoting good mental health could help to stack the odds more in favour of people who are trying to cope with a range of social and economic problems. It could also make a significant difference to those who are trying to survive their experience of mental health problems – often in a climate of social and economic hardship, and in the face of various kinds of oppression.

Given the potential benefits to London of taking this positive approach, surely it is time to look at the many factors that can affect the mental health of Londoners, and try to turn off the tap, rather than trying only to mop up the flood.

What was the situation in 1997?

The notions of actively promoting good mental health and reducing mental health problems are not new. In 1997, the report of the King's Fund London Commission stated:

> *Mental health services development should be reframed within a wider, more inclusive approach to mental health within national and city-wide policies. This 'paradigm shift' should include action at national level to promote mental health, and reduce the social and environmental stresses that contribute to mental illness.*
>
> King's Fund London Commission (1997, p 94)

What has changed since 1997?

In 1999, the theme highlighted in the King's Fund London Commission report was picked up and endorsed in the National Service Framework for Mental Health, Standard One which stated:

Health and social services should:

- *promote mental health for all, working with individuals and communities*
- *combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.*

(Department of Health 1999a, p 14)

Given the potential benefits to London of taking this positive approach, surely it is time to turn off the tap, rather than trying only to mop up the flood.

Half of all women and one-quarter of all men will be affected by depression at some time in their lives.

In support of that standard, the NSF-MH noted that mental health problems can result from a range of adverse factors associated with social exclusion, including:

- unemployment
- child poverty
- abuse and domestic violence
- rough sleeping
- drug and alcohol problems
- physical illness.

Mental health problems can also be a cause of social exclusion in themselves. The NSF-MH also notes higher rates of mental disorder in some black and minority ethnic (BME) groups, with refugees being particularly vulnerable, and recognises that half of all women and one-quarter of all men will be affected by depression at some time in their lives. All of these factors have particular relevance to London, with its particular demographic profile, and the scale and range of the challenges that London faces (*see* Chapter 3, on the special features of London's population).

In spite of this important recognition of factors that undermine good mental health (and, by inference, those that promote it), we are left with two major problems. First, at a local level, there is scant evidence that serious attention or adequate resources are being applied to promoting good mental health, or towards preventing mental health problems. However, in spite of this, there are examples of projects set up to develop communities, schemes to implement mental health well being policies in workplaces and local projects to support families and individuals to improve their mental well being.

Second, at the national level, policy is attempting to reduce risk factors in a number of areas, with efforts to tackle child poverty and rough sleeping being cases in point. However, there are also major areas in which government policy at the highest level can be construed as unhelpful to the mental health of some socially excluded groups. Policy towards asylum seekers would be an illustration of this point, and this is discussed further later in this chapter (p 113).

What is the policy context for mental health promotion?

The National Service Framework for Mental Health

As noted above, the policy context for the promotion of mental health centres around the National Service Framework for Mental Health (NSF-MH). The NSF-MH states that through health improvement programmes and local mental health strategies, local health and social care communities (including local health authorities, local authorities, NHS trusts, primary care trusts, and the independent sector) should develop effective mental health promotion for:

- **whole populations** through initiatives to promote healthy schools, healthy workplaces and healthy neighbourhoods
- **individuals 'at risk'** supporting new parents, unemployed people, and families in distress, for example, making use of local self-help groups
- **vulnerable groups** including specific programmes for BME communities, people who sleep rough, those in prison, individuals with alcohol and drug problems, people with physical illnesses, and others at greatest risk
- **action to combat discrimination** and to promote positive images of mental health problems.

Local strategic partnerships

MHI Working Paper 1 on health promotion (Heer and Woodhead 2002) noted the potential of local strategic partnerships for developing holistic responses to complex issues. However, there were problems related to the enormity of the strategic agenda, the proliferation of local strategies, and the high number of partnerships within which people were expected to work. Some local policy managers found it difficult to monitor progress, as they were overwhelmed with strategic developments.

Engaging with local implementation teams

Local implementation teams that had been specifically set up to improve mental health services did not always welcome health-promotion colleagues. It was often easier to make the case for preventative work with colleagues from sectors not directly involved with mental health work, as their interest were not clouded by 'traditional' views of mental health and illness. However, in some boroughs, integration had been achieved, through the perseverance of individuals dedicated to improving the profile of mental health promotion locally.

Community regeneration

The community regeneration agenda has a strong focus on promoting mental health, and the National Strategy for Neighbourhood Renewal provides many opportunities for taking this forward. Across the capital, there are examples of regeneration projects being developed to improve the mental health and well being of residents, although much more could be done.

Local delivery plans

The development of health improvement and modernisation plans, now replaced by local delivery plans, has helped establish partnerships to reduce health inequalities. However, public involvement in the development of strategies remains underdeveloped.

Changes in commissioning and organisations

As we have seen elsewhere in this report (Chapter 2), organisational changes in commissioning and provider organisations have been a major distraction from some of the work to which people would have liked to accord a greater priority than has actually been possible. Low morale and job insecurity have tended to distract people from tasks such as mental health promotion. Also, in spite of the lip service paid to the importance of health promotion, health organisations hold a prevailing view that individuals and organisations would be judged on more immediate and visible priorities, such as expenditure on drugs and waiting times.

Why does mental health promotion and the prevention of mental illness have a relatively low profile?

Heer and Woodhead sum the problems up neatly:

> *Across London, the development of local mental health and well being strategies has been inconsistent. Co-ordinating partnerships and engaging*

Mental health promotion has become one of those areas that almost everyone will applaud in theory, so long as they are not required to devote significant resources into making it a reality.

agencies in the process is a challenge, and often there has been little clarity about what mental health promotion is, and what it can achieve. Low levels of commitment, small dedicated resources and poor profiles make sustaining the work difficult. Organisational change poses additional challenges, as it can threaten continuity. National policy and local activities tend to focus on the delivery of services rather than developing a preventative agenda, and strategies seldom affect the commissioning of projects, or encourage innovation.

Heer and Woodhead (2002, MHI Working Paper 1, p 1)

As a result of all these factors, mental health promotion has become one of those areas that almost everyone will applaud in theory, so long as they are not required to devote significant human or financial resources into making it a reality.

Given that everyone in the mental health field would dearly love to reduce mental health problems, why should this be so? An imperative to meet short-term targets and an undue emphasis on what is easily measurable – rather than what is significant – can certainly get in the way of taking a more far-sighted view of what promotes mental health. However, even the relentless burden of performance targets and the pressure on beds and community services go only some way to explaining the collective apathy towards mental health promotion.

Defining mental health promotion

Often, a lack of an agreed definition of mental health promotion stands in the way of action. People interpret the term differently, and it is perhaps not surprising that if they cannot agree on what it is, they will not be able to agree on robust evidence of whether or not it works. Heer and Woodhead found that evidence of effectiveness had a strong role to play in making the case at a local level for mental health promotion, but good evidence was not always sufficient to persuade sceptical colleagues. It was sometimes easier to make progress when co-ordinators pointed to concrete examples of what agencies could contribute, supported by an evidence base. But even so, the claims of qualitative research were sometimes dismissed.

It was not always easy to agree on what constituted evidence of effective mental health promotion. People working in the mental health field – including those who attended King's Fund workshops – found that weighing it up would be a near-impossible task. Furthermore, it remained difficult to make a coherent economic case for some of the proposed activities and projects.

While robust evidence is extremely important, the difficulties of making widespread progress with mental health promotion suggest that evidence for some kinds of activities is given higher credence than evidence for other kinds of activities – particularly those activities that are less medically focused. This may be particularly so for mental health promotion, in spite of the continuation of widespread dissent about the effectiveness of most mental health therapies, from particular drugs to counselling.

Challenges

At one level, the mental health promotion debate is a national – or even international – one. At another level, it is very much a London issue. If there are effective ways to promote mental health and reduce the burden of mental illness, London would have an enormous amount to gain. With its diverse population, if community development and regeneration were closely tuned to local needs and strengths, this could potentially make a big difference to mental and physical well being.

This would require more attention to be paid to reaching a consensus on what constitutes mental health promotion, and how its benefits can be evaluated. Indeed, efforts to assess the health impacts of policies at national, regional and local levels should include consideration of issues of mental health and well being. It would also mean agreeing on a reasonable timescale for evaluating the impact of mental health promotion. The enormity of some of London's social problems means that turning them around is more like manoeuvring an oil tanker than a London taxi.

The growing recognition of partnerships between health, local authority and voluntary bodies can only be good news for promoting mental health. Mental health promotion is emphatically not just the responsibility of the NHS – in fact, the NHS is probably one of the lesser players. The actions of local authorities have a great impact on local people, but there remains a concern that they are not as aware of the needs of their vulnerable residents as they might be. All partner agencies need to work together to tackle the stigma and discrimination that still results in social exclusion for many people with mental health problems.

The expertise of the voluntary sector is not always valued as much as it could be. Even if it is recognised in principle, the difficulties that BME voluntary organisations, for example, have with sustainability remains a big issue – and one that can reduce their ability to contribute as fully as possible (Keating *et al* 2003, MHI Working Paper 5, Levenson and Jeyasingham 2002).

The role of central government is also pivotal to the efforts made by all other parties. In many ways, this is recognised, and a great deal of money and support has been devoted to initiatives such as Sure Start and New Deal for Communities, which are based on the idea of 'looking upstream' for the root of problems, and attempting to deal with social exclusion. However, at the same time, in some areas much more can be done, while in others, government policy can be seen to undermine the mental health and well being of some sections of the community (*see* Chapter 3).

All partner agencies need to work together to tackle the stigma and discrimination that still results in social exclusion for many people with mental health problems.

Getting into work

One area in which more still needs to be done is unemployment, which remains a major issue for parts of London. In May 2002, Hackney and Lewisham had unemployment rates of 13.6 per cent and 12.5 per cent respectively – higher than those of other inner-city areas, such as Glasgow (11.8 per cent) and Liverpool (11.1 per cent), and substantially higher than the British average of 5 per cent (Office for National Statistics, available at: www.nomisweb.co.uk). These rates are also greater than those in other European cities, such as Barcelona, which had

6 per cent unemployment in 2000 (Metropolis, available at: www.metropolis.org/metropolis/gcities.nsf).

In King's Fund discussion groups, service users were very concerned about employment issues. Each group raised these fears spontaneously, without any prompting. They talked about the difficulties of getting back into employment following a mental health diagnosis. People with forensic histories found it almost impossible to secure employment.

Service users spoke of people being denied opportunities because of the stigma associated with mental health problems. They also discussed the lack of confidence that is common among mental health service users, and noted that volunteering was helpful in building up confidence. Many were concerned that one person's Disabled Living Allowance had been cut because he was found to have been doing voluntary work.

When mental health service users did succeed in finding employment, the timing of appointments and therapies were often very difficult for them. It was hard to admit that an appointment with a psychiatrist was the reason for not coming into work. Service users also discussed problems about benefits, and in particular, they were worried about not getting back onto benefits quickly enough if they took a job that did not work out.

Housing benefit caused particular problems, since delays in reinstating benefits can result in large arrears of rent. There was also evidence of the need for improved access to advice on benefits. All of these issues are already well known, but more attention to address them remains necessary:

> *Between being well enough to work and coming off your benefits, there is a lot of fear for people.*
>
> *It's a big risk going back to work... even when we know we are fit for work.*
>
> *I've known people go on wards and their benefits are cut or wiped out. I've known people not know this, and months later go back out to the community and find that they owe money to one of the benefits agencies.*
>
> *There's an awful fear around benefits and mental health because all the forms are geared to people with physical disabilities, and you have to expose yourself. If I had a physical disability, I could say 'I've broken my leg and I limp a bit', but instead I have to say 'I hear voices and I can't always dress myself if I am feeling down.'*
>
> *It's difficult, because they will ask you questions like 'What distance can you walk unaided?' and you think 'Well, you know, if I'm in a deep, deep depression I don't leave my bed – so what do I put in there?'*
>
> Participants, King's Fund discussion groups

For the mental health workforce and mental health service users alike, housing is a huge issue.

Finding somewhere to live

Housing is another area of social policy in which mental well being might be improved by a stronger steer from central government (*see* Chapter 7). For the mental health workforce and mental health service users alike, housing is a huge issue, and nowhere is this a more pressing issue than in London. Much is being

The development of mental health services is not an entirely separate issue from that of promoting mental health.

done, but so much more could be done to ensure decent and affordable housing for Londoners. It is likely that better housing would improve mental well being for many people. At the very least, it would enable people with mental health problems to leave hospital when they are ready to do so, as well as enabling London's mental health workforce to remain where they are needed, to care for Londoners with mental health problems.

The situation for asylum seekers

For some sections of the community, government policy seems to be at odds with mental health promotion, and current policy relating to asylum seekers is one illustration of an area in which the promotion of mental health has apparently been way down the agenda, and has been trumped by other – political – considerations.

As we have seen in Chapter 3, the policy of dispersing asylum seekers to locations outside London is so unpalatable to a significant proportion of asylum seekers that they choose to stay in London with only basic subsistence, in order to be in a place where they may be able to access informal support in the environment of the country's most cosmopolitan and tolerant city. However, the level of poverty on which they must subsist undermines their own well being, and puts a disproportionate responsibility on the areas of London in which they settle without proper support. (These tend to be areas that already have major social and economic challenges.)

If applications for asylum were dealt with more efficiently and sensitively, and the needs of asylum seekers were better recognised, London would be better able to support asylum seekers, who – as we have seen in Chapter 3 – experience high levels of mental health problems. Attempts to shift asylum seekers outside London are unpopular, and do not in any case achieve the stated aims of delivering better support in a way that shares responsibility across the country.

Immediate priorities

In addition to assessing the health impacts of policy at all levels, some immediate challenges need to be addressed. If the call for better mental health promotion is to move beyond rhetoric, specific activities need to be defined and costed, and the results and costs and benefits need to be evaluated. There is a need for integrated, effective commissioning of programmes and projects promoting mental health and well being. This is unlikely to happen until mental health professionals of all disciplines receive better training on mental health promotion.

It is also important for health and social care professionals to appreciate that the development of mental health services is not an entirely separate issue from that of promoting mental health. They are two sides of the coin, which need to be considered together. For example, providing support to children and young people, and developing child and adolescent mental health services, is an important aspect of promoting mental health for the future.

Mental health promotion needs strong support from central government, and from the highest level of health and social care organisations. In MHI Working Paper 1, Heer and Woodhead note the value of identifying and nurturing local-level mental

We found a lack of consensus on what promoting mental health or preventing mental health problems meant.

health promotion champions, who include community leaders, key voluntary sector personnel, and councillors. These individuals are instrumental in keeping mental health promotion on the agenda in a range of forums and agencies. They are outspoken people who are able to see the connections between strategies, and can see their potential in promoting mental health. They themselves need recognition and support if they are to maximise their effectiveness in promoting the mental health of Londoners.

The National Service Framework for Mental Health aspires to promoting positive images of mental health, yet the old problems persist: concentrating on treating 'illness', while failing to promote mental health in a concerted manner. Given the tenor of debate about the reform of the Mental Health Act, and the continued preoccupation of politicians and the media with risk and dangers to society, we must ask where the leadership for positive images of mental health, and a better understanding of mental health problems, is to come from. Until we achieve this, the balance between promoting mental health and treating and caring for people with mental health problems is unlikely to be the right one.

Conclusions

Throughout this inquiry, there was little dissent from the principle of trying to reduce the amount and severity of mental health problems in London, and to minimise the effects that mental health problems can have on people's lives. However, we found that there was a lack of consensus on what promoting mental health or preventing mental health problems meant, and little agreement on which activities and initiatives would contribute to better mental health and how to evaluate their effectiveness.

In addition, public policies did not always promote mental health – for example, in moving asylum seekers to parts of the country where they were isolated from community networks and support. This points to a need for more courageous leadership from government, to promote better understanding of what improves, or adversely affects, the public's mental health.

The 2003 King's Fund inquiry heard of many community development and regeneration initiatives that may directly or indirectly improve mental health. A greater focus within these initiatives on the needs of mental health service users would be most welcome. Although a detailed study of employment issues was not part of the scope of this inquiry, this is widely recognised to be a major problem for mental health service users. Opportunities for employing mental health service users could be developed as part of regeneration schemes aimed at bringing people into the labour market.

In addition, the inquiry has highlighted the importance of good housing for people with mental health problems, and its importance in underpinning their recovery and rehabilitation.

The importance of involving service users and the public in health and social care has been noted throughout this report. As well as improving individual patient choice and helping to shape more responsive services, involving people is a part of building healthier communities. Capacity building in voluntary organisations – and in particular, in small user-led organisations and black and minority ethnic organisations – is essential.

Recommendations

- The Health Development Agency needs to work together with relevant bodies to agree on a definition of mental health promotion, and to indicate which approaches, interventions and activities should be developed, so they can be costed and evaluated properly.

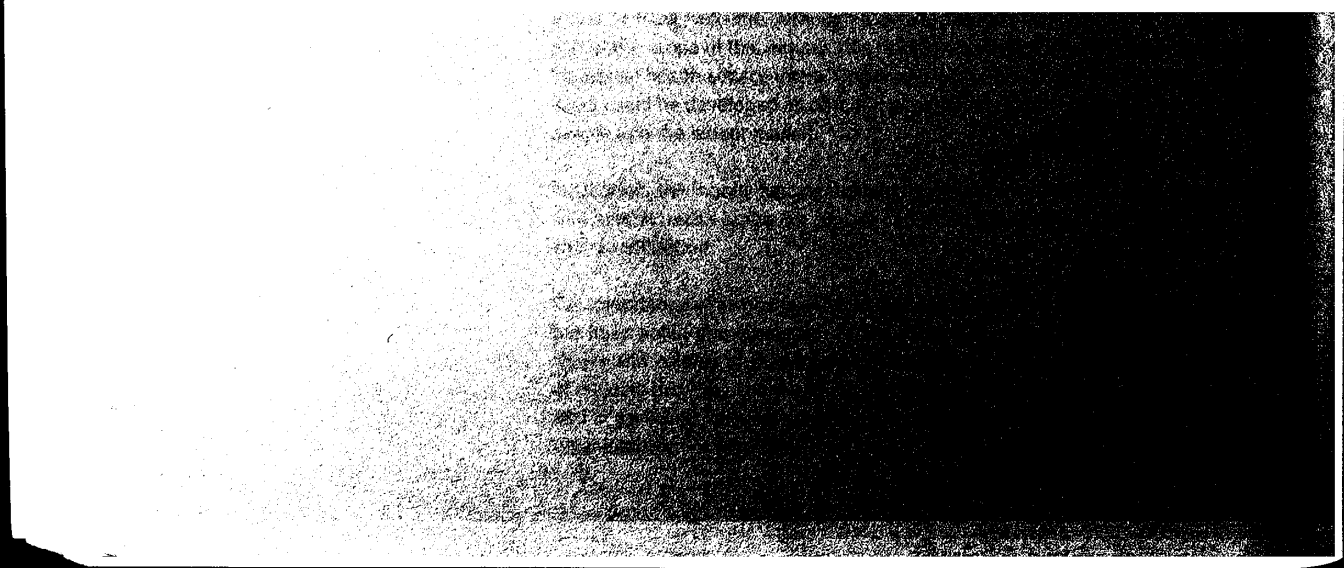
- NHS bodies, local authorities and other relevant public bodies should assess emerging new policies at the development stage, to avoid social exclusion and other possible negative effects on the mental health of communities.

- Local strategic partnerships must ensure that neighbourhood renewal and regeneration programmes contribute as fully as possible to improving the mental health of communities.

- The royal colleges and universities, alongside other educational establishments responsible for the education and accreditation of training of health and social care professionals, should provide education and training on mental health promotion. These would sit alongside more conventional courses on providing care to people with mental health problems.

- Central government, NHS bodies and local authorities must recognise the important contribution of voluntary organisations in promoting mental health, and should identify a range of measures, including capacity building and more secure funding, to enable them to develop this aspect of their role.

- Local implementation teams must ensure they have appropriate and strong stakeholder involvement that will enable them to deliver better mental health in local communities.



9 Finance

This chapter examines how expenditure on London's mental health services has changed, and whether the current levels meet the demand. In particular, it examines:

- how much is spent on London's mental health services
- distribution of expenditure across different service types
- how far funds are spent on services that show evidence of effectiveness
- whether variations in spending match variations in need
- the allocation and use of central funds targeted at specialist mental health services.

9 Finance

So far, the story of this report has been about the enormous complexity of providing appropriate services for people with mental health problems in a city with such particular needs, challenges and strengths. It would be incomplete without a consideration of the financing of London's mental health services, in terms both of what is needed and what is spent.

In this chapter, we look at what is spent across and within London, how the money is used for the various kinds of services, and how this has changed over time. Spending on mental health services in London has increased by only a modest amount over the years since the 1997 King's Fund mental health inquiry. This is despite mental health being a policy priority throughout this period, and despite major injections of extra cash through the Modernisation Fund. It is worryingly difficult to trace what happens to money allocated to the NHS for the development of mental health services. (This is less of a problem with local authority expenditure.)

There are indications that the variations in mental health spending across London can only be partly explained by variations in the need for mental health services (as reflected in variations in socio-economic factors), although social services spending is more closely related to variations in deprivation than is NHS expenditure. This chapter and MHI Working Paper 6 (Aziz *et al* 2003), on which it draws, cannot provide a definitive explanation of those variations, but they suggest the need for more work across London to look at the reasons for the variations in spending, and whether changes need to be made in order to invest in services for which there is a need, and for which there is evidence of effectiveness.

As with so many other issues examined in this report, the financial aspects require a London-wide approach, to ensure equity and to better account for the money that is spent on mental health services in and across the capital.

What was the situation in 1997?

The 1997 King's Fund mental health inquiry found that London's mental health services were under-resourced, with estimated total expenditure by the NHS amounting to £335 million. The report found that this amount fell short of meeting mental health needs in the capital by £56 million (17 per cent of the total required).

Spending on mental health services in London has increased by only a modest amount over the years since the 1997 King's Fund mental health inquiry.

What has changed since 1997?

In the five years following 1997, NHS expenditure on mental health services in London increased by only a modest amount, despite new injections of cash from the Government that were intended to modernise mental health services:

It seems that mental health is still the 'poor sister' of the health service. She may be getting a bit more money, but she still can't afford the entrance fee to the real world.

Participant, King's Fund discussion group

Comparing current expenditure levels to those of 1995/96 does not prove straightforward. Actual expenditure reported by London NHS mental health trusts in 2000/01 amounted to £477 million in total. In addition, local authority social services spending on people with mental health problems amounted to £172 million in total.

At first sight, this total spend of £649 million looks like a substantial increase in resources over the five-year-period. However, this partly reflects the increase in activity, as well as the shift in the mix of activity towards more costly types of mental health services. In any case, comparing the resources identified in the 1997 report with the current situation would be misleading, as spending was calculated on different bases in the years concerned.

To achieve an accurate comparison of spending over time, the authors of MHI Working Paper 6 adopted the same calculation methods that were used in the 1997 report. In 1997, the researchers estimated the total resources committed to mental health services by multiplying standard unit costs by service activity. Using costs as a proxy for expenditure, the trend over six years looks rather different.

There was indeed an increase in estimated NHS spending on mental health services in the capital over that time – starting at £358 million in total in 1996/97, and rising to £408 million in 2001/02. This represented only a modest increase of 14 per cent over the six years (an average of 2.2 per cent increase per year) – substantially less than the 28 per cent growth in total NHS spend since 1996/97. However, it is clear that there were also marked changes in the way in which money was distributed across different services during this time, with spending on forensic services increasing by 59 per cent, while funding for long-stay hospital beds fell by 35 per cent.

The 1996/97 report did not examine local authority spending on mental health services. That omission meant that it ignored an important source of expenditure. While spending by local councils on mental health is a very small proportion of their total expenditure, it nevertheless accounts for between 19 and 44 per cent of the total spent on mental health services in London boroughs.

Unless there is data available that shows how much money is allocated, there is little hope of fully understanding the extent to which shortcomings in London's mental health services can be attributed to lack of money.

In 2003, despite extensive efforts, it proved difficult to reach a complete understanding of the financing of mental health services in London, and most of the answers obtained led to further questioning, or drew attention to some missing part of the jigsaw. This is an important point in itself, since unless there is data available that shows how much money is allocated, and how it is spent, there is little hope of making best use of resources, or of fully understanding the extent to which shortcomings in London's mental health services can be attributed to lack of money, or to money not being well spent. However, within the limitations of the available data, this chapter summarises what we know.

Difficulties in tracking money and ensuring that it is used for its intended purpose in health and social care organisations are not unique to the mental health field, or to London. However, the Audit Commission (2003) pointed out that while it had assessed most trusts as adequate at the key aspects of financial management, newer primary care trusts (PCTs) and mental health trusts were still establishing some aspects of their managerial arrangements.

Has expenditure on mental health services increased?

This is perhaps the key resource question to ask, but it is also the hardest to answer as, given scarce resources, it would require a consensus among national and local policy-makers on what should be spent on mental health services as opposed to other forms of care.

However, in comparison with other regions, expenditure per capita on adult inpatient and outpatient mental health services is substantially greater in London, and greater than for England as a whole (Aziz *et al* 2003, MHI Working Paper 6). This is not surprising, since the non-London regions all contain sparsely populated rural areas where the prevalence of serious mental health problems is substantially lower than in urban and inner-city areas.

However, comparisons show that per capita spending in London is higher than it is in Leeds, Liverpool or Birmingham. The difference would be expected to reflect a difference in mental health need, and the complexities and level of need in London have been exhaustively summarised elsewhere in this report. Indeed, the Mental Illness Needs Index (MINI) score for London, at 1.16, was higher than Leeds (1.02) and Birmingham (0.94), but was substantially less than Liverpool (at 2.21).

This would superficially suggest that London's mental health spending was relatively generous in comparison to other cities, even after allowing for variations in need. However, the MINI is a relatively poor indicator of need. Analysis by Aziz *et al* shows that this scoring system only explains around 45 per cent of the variation in spending in London, for example. Moreover, although London may be spending more than Liverpool, for example, this may indicate substantial under-spending in Liverpool, rather than satisfactory levels of spending in London, which – as we have noted elsewhere – is in a unique position with regards to the scale and complexities of the mental health needs of its population.

What is the distribution of expenditure across different service types?

Data from London's mental health trusts shows that there were substantial variations in expenditure for all service categories. For example, in 2001/02, spending on acute beds was £49.63 per capita in Camden and Islington, compared to £13.92 per capita in Hillingdon. Considerable variation was also seen in spending on relatively new interventions, such as assertive outreach and crisis resolution.

Three trusts reported a zero spend on forensic services. However, care must be taken in interpreting this, because other trusts provide forensic services to

these areas. Establishing the specific catchment areas for forensic services is problematic, so in the full report in financing mental health services in London (Aziz *et al* 2003, MHI Working Paper 6) totals are presented with and without the forensic component. Even so, wide variations in expenditure are evident.

How far are funds spent on services with evidence of effectiveness?

Evidence suggest that assertive outreach and crisis resolution are effective interventions (Jepson *et al* 2001). These interventions were recently highlighted as services that should be implemented in all areas (Department of Health 1999a). However, spending per capita varied greatly between areas. For example, Barnet, Enfield and Haringey had the lowest per capita spend on assertive outreach, while two trusts (South West London and Hillingdon) said they did not spend anything on specialised crisis resolution services.

On the other hand, in Camden and Islington, spending per capita on crisis resolution teams was nearly six times higher than the average for London, and twice as high for assertive outreach. Given the evidence on effectiveness, it is interesting to note the high level of investment in these interventions, alongside the high level of spending on inpatient care that also persists in that area.

Whether or not the relative newness of crisis resolution teams is a relevant factor is a matter for speculation. The data available applies to the years in which crisis resolution teams were being established, and the teams may not have carried full caseloads, or worked to maximum effectiveness in their early stages. It may also take some time to fully realise the savings resulting from running down and closing beds.

The Health and Social Care Advisory Service (2003) argues that in spite of new services, the whole-system approach continues to rely heavily on inpatient care. It notes the need to recognise the fact that services such as crisis resolution, home treatment and early intervention teams are new, and that they have yet to be 'bedded down' into existing services. Only once this has happened can their impact be assessed.

Can variations in spending across London be explained by variations in population need?

Not only are there variations in spending on specific services, but there are also wide disparities in the total spending on mental health services across the 32 London boroughs. This is to be expected, given the variations in the socio-economic conditions among local populations, which are associated with different risks of developing mental health problems.

Broadly speaking, greater deprivation in inner-London boroughs indicates a greater need for mental health services than that of the more affluent areas of outer London. However, using three different models to examine the relationship between spending and mental health needs among the population served, Aziz *et al* concluded that some areas of London spend considerably more, or less, than might be predicted, given the characteristics of their local populations. Indeed, Haringey, Lewisham and Tower Hamlets have per capita spending up to one-quarter more than might be anticipated, while Hammersmith and Fulham,

There are also wide disparities in the total spending on mental health services across the 32 London boroughs.

Hillingdon, Brent, and Islington spend well below expected levels, given the social and economic characteristics of their populations.

It is tempting to view these boroughs as either over or underspending on mental health services. However, there may be a number of explanations accounting for these variations in expenditure.

These include:

- differences in the priority attached to mental health services spending
- variations in the efficiency with which services are delivered in the different boroughs
- differences in the configuration of services, particularly where services are provided across borough boundaries, leading to apparent overspending in one borough (from where services are provided), and underspending in one or more other boroughs (where some of these services will be consumed).

London boroughs and NHS trusts at both ends of the spending range need to examine their own local situations with respect to these results in order to understand and explain their levels of expenditure – with a view to making changes, where necessary, to align services with needs.

MHI Working Paper 6 (Aziz *et al* 2003) is a helpful starting point, but there are limitations to the conclusions that can be drawn from it. The researchers focused on mental health services for adults of working age, but there is also substantial spending on related services for children and older people, and for services for people with learning disabilities. In addition, changes in expenditure in one part of the system may have implications elsewhere, but to date it has not been possible to analyse spending across the whole of the mental health care system.

Finally, some of the service definitions were not consistent between trusts, and variations in accounting procedures meant that in some cases, capital and overhead costs had to be removed, based on assumptions about how much these contributed to the total expenditure. While the authors assert that the model they used was relatively robust, they advise that it still requires refining and testing.

How are central funds for specialist mental health services allocated and used?

The Government's key NHS priorities include issues such as cancer and heart disease, alongside mental health. As part of the Department of Health's strategy for ensuring that these areas received the necessary financial resources to reform and modernise, a significant part of the total increase in NHS funding over the past few years has been top-sliced from the total budget, and allocated to commissioners (formerly health authorities, and latterly PCTs) and, in some instances, directly to NHS trusts and local authorities.

Five years ago, the Government published *Modernising Mental Health Services* (Department of Health 1998a). This promised an increase in mental health spending of £700 million, spread over three years from 1999/2000 to 2001/02. It is not clear whether all of this money was eventually allocated for mental health, nor how it was distributed across the country.

In many cases, trusts were using special allocations to address underlying financial difficulties.

However, in 1999, a health circular (Health Service Circular 1999) gave detailed information about spending that was committed for mental health via the Health Modernisation Fund. This showed that £120 million over three years was to be spent, via the Modernisation Fund, on services such as assertive outreach, crisis resolution and secure care. Almost half of this money went to health authorities as part of their unified allocation. The rest was held by the Department of Health for centrally funded initiatives and services, and for distributing to health authorities and trusts via a process of bidding.

London received 16.3 per cent of all NHS money allocated in 2001/02, so it can be estimated that of the approximately £60 million allocated to health authorities over three years from 1999/2000 to 2001/02, £9.8 million was earmarked for London. The remaining £60 million held centrally has proved difficult to track, but London will have received at least the same proportion as that directly allocated to health authorities. So overall, the NHS in London received an estimated £20 million in total from the Modernisation Fund, over a three-year period, to spend on mental health services. This is likely to be an under-estimate, given London's special range and volume of mental health services.

In addition, increased funding for mental health was allocated to local authorities in the form of the mental health grant, of which local authority areas in London were allocated £27.8 million in 2001/02. Within the capital, Hackney and City and Tower Hamlets received the greatest amount per capita, while the lowest amounts went to Sutton and Bromley. The relationship between the allocation and the level of deprivation in an area (as represented by the MINI score) was strong, with over three-quarters of variation in the allocation being explained by deprivation.

Aziz *et al* (2003, MHI Working Paper 6, 2003) originally hoped to discover how such funds were actually spent. This, however, did not prove possible, because health authorities would not always have known how much was in their unified allocation for mental health.

A recent Audit Commission report attempted to address the same question on how funds were spent. It noted that tracing specially allocated funds proved difficult because 'the Department of Health does not require trusts to record in a standard way how the money was spent' (Audit Commission 2003, p 21). The report goes on to say:

> *... sometimes the extra funding was not separately identified by the health authorities and PCTs. As a result funding may not have been applied to the intended priority area because the hospital trust would not have known which area it was intended for.*
>
> Audit Commission (2003, p 22)

The Audit Commission concluded that in many cases, trusts were using special allocations to address underlying financial difficulties.

Challenges

This chapter looks back at how money allocated to London's mental health services has been used. But it is also worth looking forward to the possible implications of the Department of Health's recent financial reforms (Department of Health 2002d). That document sets out plans for fundamental changes to the way

in which funds flow through the NHS. The proposals include moves towards a nationally agreed set of prices for commissioning at specialty level, based on volumes adjusted for case mix using healthcare resource groups. The short-term focus is on commissioning elective care between PCTs and NHS trusts, but as new arrangements in primary care develop, it will extend to encapsulate all commissioning arrangements within the NHS.

At this stage, health resource groups in mental health are not imminent, but a great deal of debate is taking place about their applicability and relevance to mental health.

Conclusions

The King's Fund mental health inquiry commissioned a considerable amount of research in order to answer key questions about the adequacy, distribution and use of money for London's mental health services. In particular, it sought to understand how the current situation compared to that of 1997. There is a strong indication that NHS spending on mental health has increased gradually, but on a modest scale, and across London there are wide variations in spending – only some of which can be explained by socio-demographic factors.

Although London has a higher mental health spend that other parts of the country, this is unsurprising given the levels of need in the capital, and it cannot be assumed that London's mental health services are adequately funded.

Given the large amounts of money involved, it is a matter of public concern that it was not always possible to find out what had happened to monies specifically allocated for mental health – a point that leads to a wider issue about improving data and information on mental health services in London. The paradox about data on London's mental health and mental health services is that while there is so much information available on some aspects, it is not always easy to locate what there is, identify gaps, and make sense of the incomplete findings that are available. Sometimes, official information on service activity in London simply does not accord with local knowledge. For example, in some areas there are real gaps in knowledge about the use of funds allocated for mental health.

In particular, we support the concerns of the Audit Commission (2003) about the lack of a requirement for trusts to record in a standard way how monies for specific purposes are spent.

Recommendations

- ☑ The Department of Health and primary care trusts must develop a better and more transparent system for tracking the use of funds intended for mental health, ensuring that they are targeted at assessed needs and are not used to set against deficits in other services. The system must allow valid comparisons to be made across PCTs.

- ☑ Strategic health authorities, with the help of PCTs and their local authority partners, need to examine the reasons for the variations in spending across London on mental health, and consider whether they need to make changes so they can invest in services for which there is a need and evidence of effectiveness.

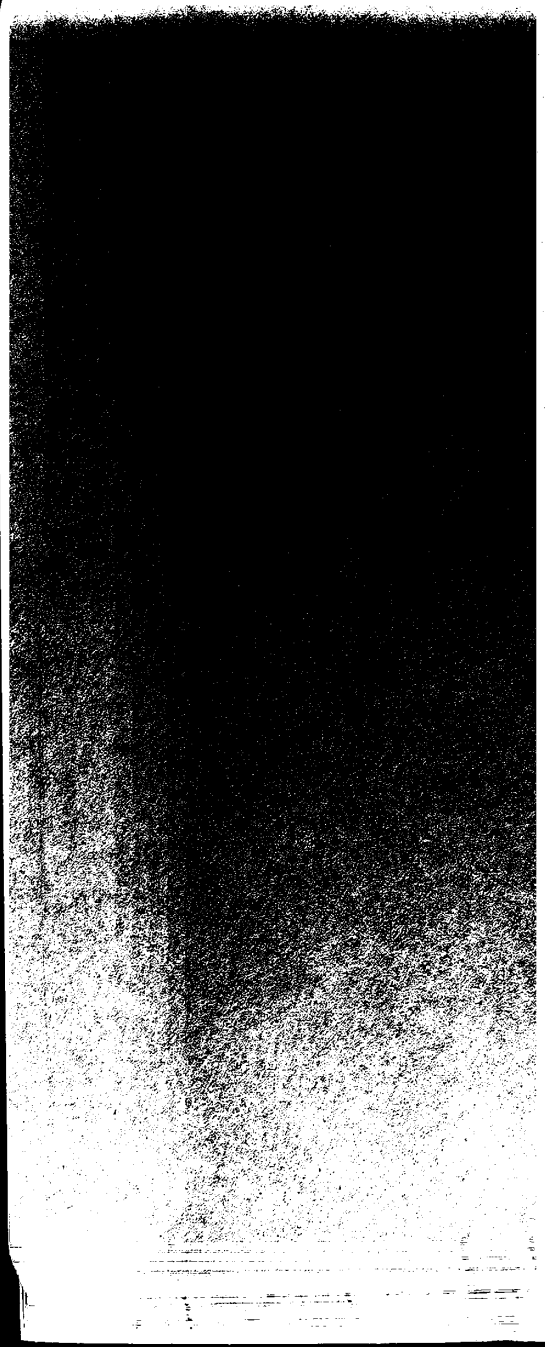
- ☑ The Audit Commission should examine levels of expenditure on mental health as part of its reviews of PCTs and mental health trusts.

- ☑ Central government, in co-operation with the strategic health authorities, should take stock of what information is available, and should state what information is needed about mental health services and spending – in particular, scrutinising how it is collected and presented in relation to how it will be used. Data should be collected in a way that enables comparisons across London, and in relation to other parts of the country. There needs to be a clear audit trail for the use of funds intended for mental health.

10 The mental health workforce

This chapter examines the issue of London's mental health workforce, looking specifically at:

- how policy developments have impacted on London's workforce
- characteristics of the London mental health workforce
- unique factors of working in London
- how attractive working in London is to the mental health workforce.



10 The mental health workforce

London's mental health workforce faces particular problems in terms of shortages of staff, high turnover rates, great challenges in the nature and volume of work, and problems of affordability of housing for staff who wish to meet those challenges. Many of the trends facing the NHS in London cannot be prevented, and must be managed. It is necessary to think creatively about solutions that go with the grain of wider patterns rather than cutting across them.

Some ways forward are identified in a recent King's Fund report (Buchan *et al* 2003). These require an effective city-wide planning and information base for its health care workforce, with a more integrated approach to planning for London's workforce. It is also necessary to 'design for transience', and to manage the high turnover, rather than to lament it, and to accept that career breaks may be taken, and to find ways of connecting people to London-based practice so that they can return later if they wish.

Although London is seen as expensive and sometimes difficult to live in, it is also one of the most exciting and dynamic places to live and work, and needs to be promoted accordingly. Only by taking these broad approaches, and by investing in London's actual and potential workforce can real, sustainable progress be made in recruiting and retaining the workforce for the NHS and for mental health services in particular that London needs and deserves.

What was the situation in 1997?

An awareness of the workforce issues that impact on London's mental health services is not new. The report of the first King's Fund mental health inquiry (Johnson *et al* 1997) referred to:

> *... very serious difficulties now arising in London in recruiting and retaining mental health professionals of all disciplines. Many services are reported to have levels of agency and other non-permanent staff over 20 per cent of total complement, with shortages of psychiatric nurses, psychologists, occupational therapists and psychiatrists of all grades. A similar concern with 'burnout' is beginning to appear in the literature...*
>
> Johnson *et al* (1997, p 40)

Although London is seen as expensive and sometimes difficult to live in, it is also one of the most exciting and dynamic places to live and work.

What has changed since 1997?

The 2003 King's Fund mental health inquiry has looked at the question of what has changed since 1997 in some detail, and a great deal of information can be found in MHI Working Paper 4, on workforce issues (Genkeer *et al* 2003). This chapter draws on that report, looking at the current mental health workforce issues in London, and considering some ways of addressing the outstanding problems.

It should be noted, however, that the figures available to researchers are patchy, as information is not always readily available about mental health posts and vacancies in NHS organisations, as Genkeer *et al* describe:

> *Definitional and data limitations make it difficult to quantify recruitment and retention problems with any certainty. Better data, collected routinely and according to national standards, are badly needed. Until then, it is difficult to judge whether the contemporary workforce in London is better equipped than that of 1997 to cope with the health and healthcare needs of individuals in London with mental health problems.*
>
> Genkeer *et al* (2003, MHI Working Paper 4, p 4)

Many of the issues discussed in MHI Working Paper 3, and in this chapter, are also relevant to other parts of the country. For example, virtually full employment, for all its benefits, also makes it harder to recruit to mental health jobs, which are seen as low paid, low status and arduous – even when compared to other available jobs in the public sector. However, for most of the issues, there is a particular London dimension, and many of the challenges are more significant in London then elsewhere.

A concise assessment of London's mental health workforce is that it is:

- ageing
- beset by high vacancy and turnover rates in some parts of the workforce
- over-reliant on temporary staff
- better able to recruit staff than retain them.

One issue of national significance that may have particular importance for London is the idea held by many staff that the most worthwhile, rewarding and career-enhancing jobs are to be found either in the community, or in the care of people in low- and medium-secure facilities. This perception may result in the workforce on acute wards suffering disproportionately from high turnover, high use of temporary staff, low morale and other related problems. Staff working on acute wards also suggest that new community teams are drawing staff away from the wards.

This is a London problem, over and above the national dimension, in that the demands made on the workforce on acute wards are particularly onerous in London, because of its:

- high rates of co-morbidity
- large numbers of detained patients
- huge range of social and housing problems
- very dependent group of patients.

The significance of this issue was underlined by the Health and Social Care Advisory Service, which argues:

> *One London inpatient ward... lost six members of its inpatient staff in one go with the setting up of a local crisis resolution team. This is a dramatic illustration of a constant trend where acute inpatient wards have taken on junior nursing staff, developed them within very difficult services, which often means allowing them to develop new skills in psychosocial interventions, dual diagnosis, relapse prevention, medication management or psychodynamic*

The Government has developed a number of policy initiatives aiming to address recruitment and retention problems across the NHS generally – and specifically, in mental health.

interventions and then losing them before the full benefit of these skills are made available to the ward.

Health and Social Care Advisory Service (2003, Section 5.8)

What policy developments have impacted on workforce issues?

The period since the last King's Fund mental health inquiry has been very active in terms of policy developments that aim to impact on workforce issues. Since 1997, in addition to the NSF (*see* Chapter 2), the Government has developed a number of policy initiatives aiming to address recruitment and retention problems across the NHS generally – and specifically, in mental health.

As we have seen in Chapter 2, at a local level, each health and social care community has a local implementation team to plan and deliver change in line with the NHS Plan (Department of Health 2000) and the NSF (Department of Health 1999a). This team comprises the statutory services for the area, together with service users, carers and local voluntary groups. Each local implementation team produces a local implementation plan, setting out how the National Service Framework standards, the NHS Plan and other changes will be translated into new local services, and how the resources provided to achieve these aims will be spent. The local implementation plan should reflect progress in all of the underpinning programmes – of which workforce is one.

The workforce and the NHS Plan

What has changed?

One of the Government's key objectives has been to build health service capacity, by boosting numbers within the workforce. The NHS Plan promised by 2004:

- 20,000 more nurses
- 2,000 more GPs
- 6,500 more therapists.

The following year, the *Mental Health Policy Implementation Guide* (Department of Health 2001c) was published. It included observations on workforce issues, particularly in relation to inpatient care staff. A subsequent section of the guide stated:

> *There is strong evidence that as the acuteness of the inpatient population has risen the time, expertise and skills targeted on inpatient services have diminished. Given the relatively low status and grading of ward staff compared to community mental health staff it is not surprising that many nurses have simply voted with their feet and left inpatient care for higher status and better rewarded jobs.*
>
> Department of Health (2002h, p 18)

Delivering the NHS Plan (Department of Health 2002e) promised a net increase by 2008 of:

- 15,000 consultants and GPs
- 35,000 nurses.

However, there are some doubts as to whether these targets are realistic.

As well as boosting numbers, the NHS Plan contained a number of initiatives to improve the working lives of staff. For example, it announced £30m by 2004 for additional childcare schemes to support flexible working patterns, as well as £140m by 2003/04 for personal development and training, and plans to modernise pay (Department of Health 1999c). It also included plans to provide training and development opportunities, and sought to increase options for flexible working, to introduce a 'zero tolerance' campaign against violence, and to better manage discrimination and harassment.

The NHS Plan also placed priority on developing career structure and opportunities for career progression. This is reflected in *HR in the NHS Plan* (Department of Health 2002f), with the promise of a 'skills escalator'. In this publication, the Department of Health states:

> *For staff it provides opportunities to develop their careers at any time of their working lives. Employers benefit from a structured programme of skills development and acquisition that supports recruitment and retention of staff, developing them to fill posts traditionally hard to fill.*
>
> Department of Health (2002f, p19)

What has this meant for London's mental health workforce?
While many of the expected improvements are yet to be seen, these plans offer a more structured framework for developing the mental health workforce in London.

Agenda for Change

What has changed?
The Government has also attempted to address staffing concerns relating to pay. In the publication *Agenda for Change* (Department of Health 2002g), it set out its frameworks for pay reform. The key elements of these include:

- a clearer connection between rewards and responsibilities
- incentives to change traditional ways of working to improve patient care
- greater flexibility for employers to pay more locally to recruit and retain staff.

Twelve sites were selected to test the new pay deal, from Spring 2003. London stands to gain the most initially – from enhanced regional pay, with more than £110 million being invested in the capital's workforce.

What has this meant for London's mental health workforce?
One aspect of the reforms that could be of particular benefit to mental health is the facility for NHS organisations to make additional payments to particular staff groups (over and above the basic pay), where these payments are needed to recruit or retain sufficient members of staff.

The consultants' contract

What has changed?
Proposed reforms have been highly controversial. For example, the promise of a higher basic salary for new consultants, and the removal of income restrictions on private practice, were not initially sufficient to convince the medical profession to accept extra on-call duties and other restrictions around private work. Doctors expressed concern that managers would have too much control over

consultants' pay, working hours, career progression and time spent in private practice (Gray 2002).

In October 2002, consultants voted to reject the contract, and negotiations continued until a new framework agreement was finally reached in July 2003 between ministers and the BMA. In October 2003, consultants in England voted to accept the new contact.

What will this mean for London's mental health workforce?
Discussions to date suggest that there may be dangers in any reduction to consultant psychiatrists' working hours, given that many currently say they have very high workloads, and that there is a known shortfall in consultant psychiatrists in many areas.

However, the new contract also offers NHS trusts opportunities to pay consultants extra money to see patients during evenings and weekends. This, together with greater clarity about what is expected of NHS consultants, may lead to service improvements.

The Workforce Action Team

What has changed?
The Workforce Action Team was established to co-ordinate work in this area, and to support implementation of the National Service Framework for Mental Health and the NHS Plan. In 2001, it produced a final report, describing its work and suggesting potential solutions to problems of recruitment and retention, poor workforce planning and poor education and training (Department of Health 2001d).

The Workforce Action Team has initiated a number of important pieces of work. One of the most significant is a framework of capabilities, entitled *The Capable Practitioner* (Sainsbury Centre for Mental Health 2001). This sets out the knowledge, skills and attitudes required by the workforce to deliver the National Service Framework for Mental Health and the NHS Plan.

> *My biggest wish really is for far better training of staff to deal with vulnerable people – for them to understand that the whole point of them being there is to be able to empathise with people and care for people.*
>
> Participant, King's Fund discussion group

A second significant piece of work is the creation of a new staffing role for new 'support, time, recovery' (STR) workers. Their role is to support service users with mental health problems, by spending more time with them and helping them cope with daily activities and access services. They are not responsible for delivering treatment or care co-ordination. The Workforce Action Team estimated that 10,000 STR workers would be needed in England, and expects some to convert from existing non-professionally affiliated roles, such as support workers in community mental health teams and acute-ward nursing assistants.

The creation of the new STR role should provide job opportunities to new populations of workers – particularly those who have survived mental health problems themselves.

What has this meant for London's mental health workforce?
It is likely to be some time before change is seen in the London workforce given the history of poor planning, variable recruitment and retention practice, and the

specific economic and housing conditions in the capital. However, London's professional workforce is now being given renewed attention. In addition, the creation of the new STR role should provide job opportunities to new populations of workers – particularly those who have survived mental health problems themselves.

The National Institute for Mental Health in England (NIMHE)

What has changed?
NIMHE is a new organisation, launched in July 2001, based within the Modernisation Agency at the Department of Health. It consists of:

- a central team, based in Leeds, providing leadership and co-ordination of NIMHE's activities
- eight NIMHE development centres, providing main points of contact for frontline teams to share experiences and find solutions that work in practice
- key priorities for action, which include establishing nine national programmes, alongside various networks and working groups, and service redesign.

NIMHE's eight regionally based mental health development centres build on and sustain the work of pre-existing regional centres and local networks. Their mandate is to drive, change and help facilitate organisational development. They have strong links with the workforce development confederations, and operate to targets set by the National Service Framework for Mental Health. The London Development Centre for Mental Health started work in July 2002.

What has this meant for London's mental health workforce?
Employment is one of the topics being addressed by the London Development Centre for Mental Health, as one of the wider issues affecting mental health and well being.

Modernising social services

Social services have also been undergoing changes since 1997, with specific workforce implications. In 1998, *Modernising Social Services* (Department of Health 1998c) was published. This included major changes to the ways workforce standards were guaranteed, by introducing clearer standards and better training arrangements. These changes were to be overseen by the new General Social Care Council.

What will this mean for London's mental health workforce?
London's mental health workforce can be expected to improve in time, with new standards and training arrangements in social care.

To what extent are these policy developments working for London?

All the policy developments outlined above contribute towards tackling the challenges facing London's mental health workforce, but the scale of the initiatives is not commensurate with the scale of the problems to be addressed. While many of the policy initiatives may take longer to make a real difference, London's mental health workforce also appears to be in urgent need of measures to support recruitment and retention. New and additional solutions need to be identified to accelerate the changes required to enable London's mental health services to function efficiently, with adequate skilled staff to run services effectively.

Approximately 150,000 of the 1 million employed by the NHS are aged 50 or over, and are therefore eligible for early retirement.

What are the characteristics of the London mental health workforce?

A number of characteristics of the mental health workforce in London are particular to the capital. They are presented in the following sections.

More part-time posts

An increasing number of consultant psychiatrists are opting for part-time posts. This trend may reflect an increased desire for part-time work, as well as a greater number of women entering the profession. It may also reflect moves to balance work with the rest of life, for women and men alike.

Ageing workforce

The workforce is getting older. Studies predict that the number of 35–59 year olds will increase over the next four years, in contrast with the expected shortfall in younger professionals (25–34 year olds). This will have significant consequences for the workforce, particularly given that approximately 150,000 of the 1 million employed by the NHS are aged 50 or over, and are therefore eligible for early retirement (Meadows 2003).

This is a national problem and not just a London problem, but there are specific issues for London:

- Within London, there is a lower turnover of mental health nurses than there is in adult general nursing. This may indicate that there is an older and more stable workforce in mental health nursing. While this stability has certain benefits for psychiatric nursing for the present time, active planning is required for the future as the older nursing workforce retires. Also, for now, younger staff can find it harder to progress their careers where the workforce is top-heavy with more senior staff.

- GPs in London are, on average, significantly older than GPs across the country. London has significantly fewer GPs aged 35–49 than in England as a whole, and significantly more GPs aged over 50 than the England average (Department of Health: Statistical work areas: Workforce. Available at: www.doh.gov.uk/public/stats3.htm)

- Many of the GPs recruited to the UK from South Asia in the 1970s are now nearing retirement. In some areas – particularly in London – this could mean the loss of one-in-four GPs in the next few years (Taylor and Esmail 1999).

High vacancy and turnover rates

Again, this problem is not unique to London, but is particularly serious within the capital, where there are many other employment options open to potential recruits. Generally, the turnover of NHS staff in London is higher than the national average, especially in inner-city and teaching NHS trusts (Buchan *et al* 2003). Service users at a King's Fund discussion group were aware of this problem, and wanted to see a greater continuity in staffing. The high turnover rates on acute wards made some people feel that patients were treated as 'just a number'.

Reliable figures for mental health staff turnover are hard to come by, as information is often collected in a way that does not enable comparison between London and elsewhere, and not all trusts had information for all the professions involved in mental health. Nor do we know what would represent an appropriate turnover rate, allowing for an appropriate balance to avoid the twin perils of stagnation, on the one hand, and too-rapid change on the other.

Relying on temporary staff

Staff shortages are much worse in the capital than in most other parts of the NHS, and the demand for staff is expected to grow markedly over the next few years as the population grows. The Health and Social Care Advisory Service notes that on acute mental health wards, London has low numbers of staff in post compared to the number of posts that are currently in place (Health and Social Care Advisory Service 2003). London is also more reliant than other areas of the NHS on overseas-trained staff and temporary staff, who are employed to help fill gaps (Genkeer *et al* 2003, MHI Working Paper 4), but retaining overseas staff is not easy, and many remain for a relatively short period.

The number of agency staff currently employed within the NHS is difficult to quantify accurately. London stands out from the rest of the NHS because of its very high use of temporary nursing staff, and its far greater reliance on external agencies than that in other parts of England.

The establishment of NHS Professionals as an in-house NHS staff agency is to be welcomed as a recognition that temporary staff are likely to be a persistent feature of the workforce for some time to come. It should enable a better managed and more economical approach to employing and managing temporary staff once the initial problems in the NHS Professionals pilot sites have been ironed out.

Mental health and the primary care workforce

The 1997 King's Fund inquiry identified several areas of concern about the mental health workforce in primary care. Specifically, it noted among primary care staff a lack of skills in managing mental health problems effectively.

GPs tend to see a substantial number of patients with mental health problems, as they are the first point of contact for care, serving as 'gatekeepers' to wider services. As such, the primary care setting provides the greatest opportunities for detecting and preventing mental health problems.

Nevertheless, many GPs lack confidence in managing and treating mental health problems, which may reflect the fact that less than 30 per cent of GPs have held a postgraduate psychiatric post (Department of Health 2001d). Moreover, GP shortages in some areas of London are acute – particularly in inner and east London – and many GPs are already over-burdened by large caseloads. There has been a slight fall in London in the number of whole-time equivalent unrestricted GP principals (down 0.13 per cent from 1999 to 2001), compared with a slight growth (0.13 per cent) in England as a whole, during the same period.

On acute mental health wards, London has low numbers of staff in post compared to the number of posts that are currently in place.

In an article for the *International Review of Psychiatry*, Jenkins (1992) highlighted the importance of using secondary care staff to provide an educational and supportive role to the GP and others in the primary care trust, in order to treat

There is an urgent need to obtain reliable data on the profile of staff employed in prisons, including mental health staff.

individuals with depression appropriately. Jenkins also encouraged the employment of practice nurses, counsellors and health visitors to work within the mental health domain, to support GPs, and enhance their capacity to treat patients with depression and prevent it from progressing. However, while there is evidence of some improvements in the overall quality of primary care mental health services, questions remain as to the long-term effectiveness of counselling services provided within general practice.

The mental health workforce in prisons

The issues of staffing in prisons and the mental health services available to prisoners are largely beyond the remit of this report. However, with the planned transfer of mental health commissioning to London PCTs from April 2004 and later planned developments in mental health services for prisoners (some the subject of targets in the NHS Plan), there is an urgent need to obtain reliable data on the profile of staff employed in prisons, including mental health staff. This would enable better understanding of the needs of the specialist and non-specialist prison workforce who come into contact with prisoners with mental health problems. It may also have implications for the support needs of these same people when they leave prison, and the workforce needed to offer that support.

What factors are specific to working in London?

Many of the issues described in this chapter are national issues – albeit with a London flavour. In this chapter, we look specifically at factors where the London angle has particularly significant consequences. Specifically, we will look at:

- whether London's mental health services are harder to work in than services elsewhere
- whether London is affordable for the mental health workforce.

Are London's mental health services harder to work in than services elsewhere?

Workload and stress levels

As we have seen in Chapter 6, there has been a slow but steady increase in community mental health services, providing an alternative to hospital admission, but inpatient services in London remain under great pressure. Occupancy rates for acute beds have continued to be high, at around 95 per cent for much of the period since the King's Fund's 1997 report.

In fact, there has been a small rise in bed occupancy during this period, and the pressure on beds is greater in London than elsewhere. Also, as we have seen, there has been an increase in secure beds in London, and throughout the five-year period London continued to have the highest number of secure beds compared with all other regions. London also has twice as many compulsory admissions per capita as other regions.

We have also seen that the London workload is heavy because of the demands of caring for people with dual diagnoses. There is, as yet, an inadequate knowledge and understanding of how this affects workload, stress levels at work, or risk to staff and/or patients. More work needs to be done on these issues, and to identify the extent to which there is a 'London factor'.

Interviews with staff in London mental health trusts found that all the nurses interviewed said they had felt concerned for their personal safety at work.

What we do know is that anecdotal evidence reinforces the findings of a survey carried out by the NHS Executive in 1998/99, which found that there were approximately 65,000 violent incidents against NHS trust staff in England each year. In mental health or learning disability trusts, the average number of incidents was more than three times the average for all trusts (NHS Zero Tolerance Zone. Available at: www.nhs.uk/zerotolerance)

Interviews with staff in London mental health trusts carried out for MHI Working Paper 4 (Genkeer *et al* 2003) found that all the nurses interviewed said they had felt concerned for their personal safety at work. Many had been personally threatened, or had witnessed threatening behaviour. Experiences ranged from verbal violence and racial harassment to threats or actual physical violence. In some instances, staff had become aware that guns were brought on to a ward.

Some staff acknowledged that they had experienced mental health problems themselves as a result of violence and abuse at work. This is not to say that staff are uniquely affected by these problems. Service users are equally affected, and in group discussions for the 2003 mental health inquiry, some report aggression by staff as well as towards staff (*see* Chapter 6). Tackling aggression and violence in mental health services, and the culture that gives rise to these problems, would benefit staff and service users alike.

Another recent report (Health and Social Care Advisory Service 2003) refers to equally serious incidents, and confirms that violence and aggression are a real fact of life for many inpatient workers. It also argues that while 'zero tolerance' of violence and aggression may be unrealistic, 'zero complacency' is very much wanted. It reports that many trusts are seeking to address these issues, and directs a number of concerns towards the police and the Crown Prosecution Service.

In MHI Working Paper 4, Genkeer *et al* (2003) found that staff often made a distinction between patients who were violent or aggressive because of their mental health condition and those who were violent because of alcohol or drug use. The latter were thought to be behind most violent confrontations. Many mental health patients on acute wards were reported to have substance misuse problems, and there were anecdotal accounts of drug dealers coming onto the units to supply illegal drugs, as well as patients themselves dealing in drugs (*see* Chapter 6). Some nurses had been threatened by drug dealers, and support from the police was not always adequate or effective.

Even if such events are not everyday occurrences – and we do not have the data to know whether they are – the impact of working in a climate of fear and potential intimidation cannot be overstated. Researchers for MHI Working Paper 4 (Genkeer *et al* 2003) found that a degree of denial about the impact of such problems was endemic at all levels. Even staff who reported guns on the ward appeared to feel that the 'normal rules' that apply elsewhere do not apply to mental health settings. Some staff may seem to accept such extraordinary challenges as 'simply part of the job', and their managers may do so too. However, this only lasts until it all gets too much and highly skilled staff realise that they can find less stressful ways of earning a living.

Social problems

As we have seen in Chapter 3, London has a wide range of distinctive features, and large numbers of people with social problems. Apart from the impact of these

factors on the volume of work, for many of London's mental health staff the workload is more difficult as a result. Poverty, social exclusion, homelessness and substance use all add to the complexity of the workload of mental health professionals in London.

Many such professionals enjoy the challenge of trying to help alleviate the consequences of social problems, but 'burn out' is not infrequent. Some staff say they feel competent at dealing with the mental health aspects of people's problems, but that they do not have the wherewithal to tackle social problems such as homelessness. On a bad day, the scale of the challenges, combined with the costs of living in London, may become too much for even the hardiest worker.

Ethnic diversity

London's ethnic diversity is sometimes cited as an example of another way in which London is a tougher working environment. This assumption needs to be looked at critically. We have seen in Chapter 3 that rates of mental health problems can vary according to factors of culture and ethnic origin, and that some asylum seekers and refugees have particular mental health needs because of their experiences in their countries of origin and in this country. Professional groups told the King's Fund that ward staff sometimes felt under-equipped when helping asylum seekers and refugees – particularly those with post-traumatic stress disorders. We have also seen that black men are more likely to be compulsorily detained than white men.

However, while these factors may result in a larger number of people from minority ethnic communities using psychiatric services, that in itself does not make the services more difficult to work in. In fact, the difficulties arise from:

- pressures on staff that make it difficult to deliver individual, person-centred care
- lack of resources for language support and advocacy
- a persistent lack of services perceived as culturally appropriate by black and minority ethnic patients.

In this, as in many other aspects of the workforce question, the high demands on the service both reflect and cause staff shortages.

A major concern is that workforce development issues have mainly been addressed through training initiatives, rather than co-ordinated strategies to improve staff competence on issues of race and culture (Keating *et al* 2003, MHI Working Paper 5). Although London's mental health workforce is quite diverse, a more strategic approach to improving cultural competence would be of benefit to all.

Organisational and job instability

Professional groups told the King's Fund that ward staff sometimes felt under-equipped when helping asylum seekers and refugees.

The 1997 King's Fund mental health inquiry found high levels of organisational and job insecurity. In 2003, this is still the case. Commissioning organisations and mental health trusts have all been reorganised during this period. It is not easy to assess what impact this has had on the workforce, but it is not unreasonable to assume that the positive factors, such as the stimulating environment of a new organisation, may have been balanced or outweighed by more negative factors, such as job insecurity (particularly for managers), the stress of competing for new positions, additional work, office moves and other related factors.

There is simply no information on whether this set of factors in London's commissioning organisations and mental health organisations is similar or dissimilar to that which prevails in other parts of the country. It would be interesting to know more, and in particular, to know more about whether turnover rates in London reflect the fact that mental health professionals in the capital have a greater choice of places where they can work than staff in many other parts of the country.

How attractive is London to the mental health workforce?

In addition to considering the particular challenges of working in mental health in London, workers also need to consider whether they feel London is a place in which they wish to live and work – and whether they can afford to do so. There are many positive aspects of London life, and much more needs to be done to make these known. The negative aspects are all too obvious to a workforce whose skills are so much in demand elsewhere.

Housing and the cost of living

Genkeer *et al* (2003, MHI Working Paper 4) report a growing disparity between the cost of living in the capital and the earnings of key public-sector workers, and this is supported elsewhere. Writing in *Society Guardian*, Matt Weaver argues:

> *Central London is fast becoming a ghetto for either the very rich or the very poor. Those on average incomes are excluded, including hundreds of thousands of public sector workers vital to the wellbeing of the city.*
>
> Weaver (2001, p 1)

The article goes on to explain that although housing associations build around 25,000 new homes for rent each year, about 50,000 council homes are lost each year through the 'right to buy' policy. As a result, many key workers on whom London depends earn too much to be able to qualify for social housing, but not enough to buy property. Instead, they have to rent privately (often at unsustainable levels of rent), share housing, commute long distances, or choose to work where housing is more affordable. There is also the vexed question of who counts as a key worker. Health and social care services depend as much on cleaners, porters and voluntary-sector workers as they do on doctors, nurses and frontline care staff, but rarely are the former included as 'key workers' for access to affordable property.

Many of those who train in London cannot afford to stay after they complete their training. In August 2002, the average cost of a flat or maisonette in Greater London was £176,800 – twice that of the next most expensive region: the south east. Assuming a 100 per cent mortgage on three times average earnings, the salary required to buy into the London housing market at this price is almost £60,000 (Buchan *et al* 2003). It is abundantly clear that many of London's mental health workforce will probably never be able to buy property in London – a fact of life that they share in common with many of their service users.

Although the Greater London Authority/MORI (2000) recognises the importance of this issue, it is hard to be persuaded that there is any organisation – nationally or London-wide – that is able to match strategic analysis and commitment with the

resources necessary for addressing the problem of housing for low-paid workers in London.

Availability of other employment

London's mental health workforce is in a position to 'vote with its feet'. There are mental health posts available to them elsewhere, and there are opportunities in other fields of employment, should they choose to take them. The dedication of the lower paid sections of London's mental health workforce in continuing to take on the challenges of working in some of the most challenging positions for so little financial reward, and with current levels of support, is an amazing tribute to the workforce itself. However, their goodwill cannot be taken for granted, and any complacency in addressing the problems that face the workforce can only lead to more workers choosing to work elsewhere, with adverse consequences for the remaining staff and service users alike.

Challenges

Better data for workforce planning

At present, the information currently used for workforce planning is inadequate to enable an indepth knowledge and understanding of workforce issues in London. Much of the information used in this chapter comes from research drawing from data that was patchy, or hard to come by. As well as better data on the mental health workforce in primary care, community services and hospitals, better information is also needed on the workforce responsible for prisoners with mental health problems.

Better data would support workforce planning. In its publication *A Mental Health Workforce for the Future*, the Sainsbury Centre for Mental Health sets out clearly why workforce planning is so important:

- *It enables organisations to plan for the future particularly on elements of the infrastructure needed to achieve organisational goals.*
- *It helps organisations to integrate business and human resource plans.*
- *It provides better management of staffing and costs.*
- *It enables analysis of staff utilisation.*
- *It focuses on current and future skill requirements.*
- *It profiles current staff, so that equality of opportunity may be achieved.*
- *It highlights industry sector staffing needs and deficiencies.*
- *It stops reliance on uninformed perceptions of labour markets, both present and future.*
- *It creates a clear understanding of current and future issues, and supports planning and implementation to specifically address them.*

Sainsbury Centre for Mental Health (2003, p 13)

Any complacency in addressing the problems that face the workforce can only lead to more workers choosing to work elsewhere.

London has a long way to go to address all those points for its mental health workforce. There is scarcely a more urgent task, if many other allied problems are to be successfully addressed.

Review of pay and conditions

Nurses do not cite pay as the only reason for leaving the profession (Meadows *et al* 2000). Nevertheless, it is a factor for nurses and other low-paid staff in mental health services – particularly when weighed against the difficulties of the jobs that they do. Living and working in London is expensive, and trusts in outer London are unable to compete with the inner-London weighting paid by neighbouring trusts just a mile or two nearer the centre of London. It is little wonder that turnover and vacancy rates are significant issues – particularly in those jobs where there are national shortages.

Retaining staff is generally more of an issue than recruitment. One challenge is to identify how to improve retention, while assessing the extent to which current retention levels are bound up with London's unique characteristics. For example, many young workers from Britain and overseas are likely to welcome an opportunity to work in London for a period, while never intending to make London their home. This may be an opportunity as much as it is a problem – particularly if the education and support needs of temporary, bank and agency staff are addressed. The creative approach, then, may be to find ways of making the best possible use of an inevitably transient section of the workforce, and of managing and supporting this type of workforce to best effect.

Tackling violence at work

As we have seen, aggression and violence remain serious concerns, for the workforce and service users alike. However, at present we do not know enough about the extent of violence and aggression on acute wards. Although many people hold strong opinions on the subject, we do not know all that we need to about how far aggression and violence are caused or compounded by the consumption of illegal drugs and alcohol on the wards. More robust information could indicate the need for changes to staffing levels, and ways of supporting both staff and patients.

A London-wide approach to affordable housing

As we have noted, affordable housing is a very big issue for London's NHS workforce, including those working in mental health. It is a particularly big concern for those workers who are deemed to be too well-off for social housing but are too poor to buy or rent acceptable alternatives. Existing schemes rarely address the needs of those workers in statutory and voluntary mental health services who are not usually considered to be key workers, but who are, nevertheless, essential to the effective running of London's mental health services.

Employing service users

There is limited information available on the number of mental health service users employed by mental health services. This is partly due to definitional problems, but in any case, not all potential employees will wish to disclose their mental health history. There are a number of initiatives, in London and beyond, supporting mental health service users to take up employment in mental health services, thus sharing their insights and experiences while taking the very important step of acquiring skills and earning a living.

London's specific problems need a creative approach over and above the usual initiatives to support recruitment and retention.

The Department of Health's guidance on support, time and recovery workers states that a current or ex-user of mental health services could make an excellent candidate. This is clearly an area worthy of further exploration that could have a big impact on the workforce, and the quality of services which it can deliver to Londoners.

Employing refugees

Some refugees already have relevant education, skills and experience in mental health services when they come to this country. Others may be interested in enhancing their existing skills and acquiring new ones. It would be helpful to examine the successes of schemes in which refugee health workers have been successfully taken up by health and social care posts, while examining the remaining barriers to finding employment in these fields. Although the number of refugees who might work in London's mental health workforce may not be great, the value of their contribution would be very significant.

Conclusions

The health and social care workforce – and the mental health workforce in particular – faces challenges across the whole country, but this is even more the case in London. This is because of three factors:

- the size and complexity of the workload
- the nature of London's workforce
- the expense of living in London, which results in problems for the workforce in acquiring affordable housing.

London's specific problems need a creative approach over and above the usual initiatives to support recruitment and retention. Improving the retention of skilled and qualified staff must be one objective of any mental health service. But in addition to this, London has to come to terms with the inevitability that its mental health workforce will continue to include a high number of people who will spend some part, but not all, of their career in London. As we have seen, this implies a different skill mix and excellent leadership at team manager and ward manager level.

There are particular concerns about the pressures on the workforce in acute inpatient services and the extent to which their status has fallen as new community-based teams are formed, and the wards lose staff to areas of the service that are seen as more exciting or rewarding – or possibly, less stressful.

While there are shortages in a number of mental health professions, there are also talents that are not put to full use. Refugees who have relevant experience or qualifications in mental health should be supported and encouraged to work in London's mental health services. Mental health service users should also be supported and encouraged wherever possible to take up employment opportunities in the service.

Recommendations

- ☑ The workforce development confederations (and strategic health authorities, when they assume responsibility for the work of the confederations in 2004) need to work together to develop a strategy for action to address the challenges facing London's mental health services. This should link in to the London-wide mental health strategy, recommended in Chapter 11.

- ☑ The workforce development confederations (and strategic health authorities) need to take responsibility for compiling robust data specifically relating to the mental health workforce in London. A minimum dataset to inform the routine and mandatory collection of workforce data across the specialties should be introduced as a matter of urgency.

- ☑ A named person in each workforce development confederation (and in the strategic health authorities) should take responsibility for helping refugee workers to enter the workforce in mental health and other services.

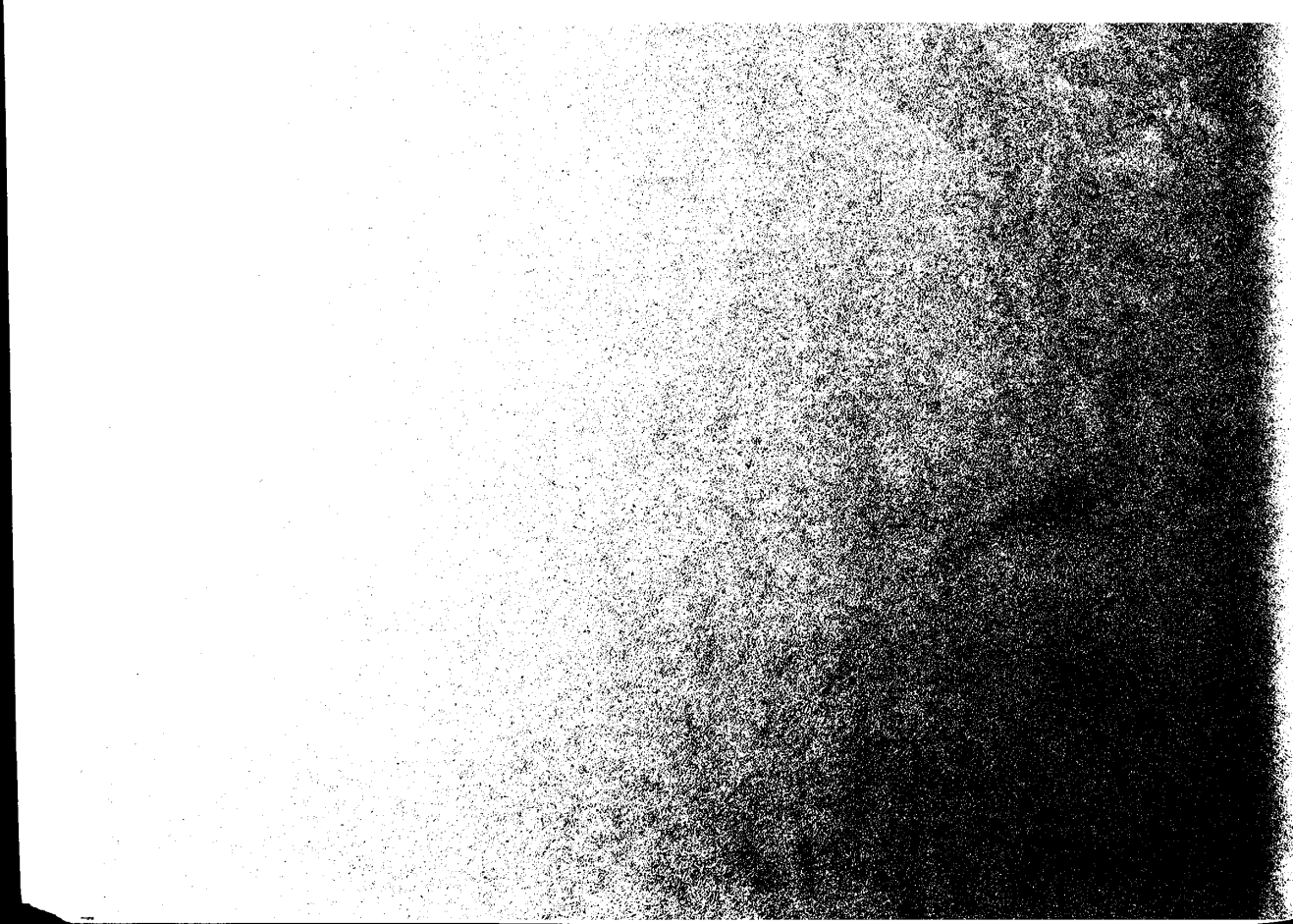
- ☑ A named person in each workforce development confederation (and in the strategic health authorities) should take responsibility for increasing the recruitment and retention of mental health service users as workers in London's mental health services.

- ☑ Mental health trusts should review the pressures on the workforce on acute wards, with a view to better training and support for that section of the workforce.

- ☑ Workforce development corporations (and strategic health authorities) should co-ordinate the collation and dissemination of good practice in recruiting and retaining staff and, liaising with mental health trusts and the London NHS human resources managers' network, should provide development opportunities for all trusts to learn from the experiences of the most successful trusts.

11 Conclusions and recommendations

The final chapter presents a summary of the main conclusions, and lists key recommendations that have emerged from the King's Fund 2003 mental health inquiry.



11 Conclusions and recommendations

Key findings

- As in 1997, the picture of mental health services and people's experience of using them remain very mixed. There are many examples of good services and practice in the capital, but the pace of progress is generally too slow. Despite efforts to address the problems identified in the first inquiry, many still persist, and the challenges remain remarkably familiar.

- Modernising mental health services has been a key strand of government health policy since Labour came to power in 1997, with the introduction of the National Service Framework for Mental Health and the promise of £700 million to modernise mental health services, as well as additional resources for the NHS as a whole. However, progress in modernising mental health services in London has been disappointing. London remains locked into using high levels of acute inpatient beds, with vital community services still underdeveloped in many areas. A disproportionate emphasis on dangerousness and risk has meant that early investment of modernisation monies has been concentrated on secure services. This has inevitably deflected attention from the continuing development of the very community services that can help people stay out of hospital.

- London has a proportionately higher number of acute inpatient beds and experiences higher occupancy rates than other parts of the country. In particular, there has been a sharp increase in medium- and low-secure beds, with the number nearly doubling in five years (although historically there has been a shortage of beds in this area). High acute inpatient bed use in London is associated with:
  - a high level of compulsory admissions (London has twice as many formal admissions under the Mental Health Act as the rest of the country)
  - a shortage of appropriate community mental health services (for example, only one-third of local implementation team areas have crisis resolution services – although these have been shown to reduce hospital admissions)
  - a high and apparently increasing proportion of people presenting with dual diagnosis (that is, problematic drug or alcohol misuse, together with mental illness). A recent study indicated that half of people with psychotic illness in London's acute inpatient beds were also substance misusers.

- In spite of redevelopment and environmental improvements to some acute wards, others are still operating in unsuitable buildings. In addition, the atmosphere in many acute wards has deteriorated since 1997, with some seen as unsafe and unattractive by service users and staff. There remains a need to address violence and aggression on the wards, and to get to grips with the challenges posed in London by the very high number of people with a dual diagnosis of substance misuse and mental health problems.

Overall, people who use mental health services still face serious obstacles in trying to lead 'ordinary' lives.

- Overall, people who use mental health services still face serious obstacles in trying to lead 'ordinary' lives. In housing, in particular, the inquiry found that funding, staffing and training do not appear to have kept pace with the increase in complexity of needs of people in the capital with mental health problems. While the capital's population has grown, the supply of suitable housing with appropriate support has remained static.

- It is impossible to determine whether a lack of resources is a factor in the slow pace of modernisation of London's mental health services. The inquiry estimated that there has been around a 14 per cent increase in spending on NHS mental health care in London since 1997. While this is welcome, it is only half of the 28 per cent increase in expenditure in the NHS as a whole, and much of the increase in the early years appears to have been used for secure inpatient rather than community services. It was not easy to trace the pathway of funds allocated to mental health, and this is a matter of public concern. There are also wide variations in spend across London that cannot all be explained by variations in need or levels of service.

- Weak commissioning of mental health services by primary care trusts is a key factor in the slow pace of modernisation of London's mental health services. The inquiry found the commissioning process to be a set of ill-matched dialogues between a small number of large mental health trusts and a much larger number of underdeveloped primary care trusts. Overall, the picture is one of duplication of effort, with expertise thinly spread. The wide gap in provision and variations in quality and provision (unrelated to need) also indicate that mental health services in London are inadequately performance managed.

- The inquiry found that little serious attention or resources are being applied at local level to promote good mental health, prevent mental health problems, or enable people with mental health problems to live their lives as fully as possible. This may be compounded by the focus by the Government and the media on risk and dangerousness, identified by users as contributing to stigma and prejudice.

The problems are not new

The NHS and social care worlds are forever changing, and this period of inquiry coincided with a stage at which some relatively new changes were just beginning to bed down, while others were at a formative stage – with a level of attendant disruption that was no surprise. So it might be tempting to suggest that, in view of all the recent policy and organisational changes, the observations made by this report are not a fair picture of London's mental health services and the challenges that they face. However, this assertion would be quite wrong. The evidence points to the fact that the trends we have observed pre-date recent changes, and that they persist even during more settled periods.

In spite of all the changes that have taken place since 1997, the challenges – and indeed, the positive aspects of services and service development – are actually remarkably familiar and similar (almost disconcertingly so, in many respects) to what was found at the time of the first King's Fund mental health inquiry and reported in *London's Mental Health* (Johnson *et al* 1997). We do, however,

recognise that some of the standards set out in the National Service Framework for Mental Health, and some of the money that is being invested in service improvements, will take a long while to have a full effect. What we have seen is often 'work in progress', with the full impact of change yet to be fully felt.

This report, along with the working papers and other material on which it draws, offers a detailed picture of key issues affecting London's mental health, and its mental health services. The durability of some of the problems is perplexing, but the fact that some of the problems are so well known, and of such long standing, is instructive. The most intractable problems, such as housing and workforce issues, persist despite many initiatives to address them, and in spite of heroic efforts by committed individuals and teams.

London's mental health services, and the allied services that support people with mental health problems in living as full a life as possible, are largely staffed by dedicated, hard-working people who are aware of the difficulties, and deeply wish to play a part in solving them. It is fair to say that if the problems facing London's mental health were easily soluble, they would have been solved by now.

London is unique

One recurrent theme throughout this report is that there is something special about London. As we have seen, London's population is unlike that of other cities in the UK, both in its size and in the range of its positive attributes and formidable challenges. London is also unlike a city such as Birmingham or Manchester in that it is not governed by one single body. Nor does any other city have 31 primary care trusts (PCTs). London's political organisation, NHS structures and commissioning and delivery of services are innately complex.

While London is unique, some of the issues it faces are also shared by other cities in the UK, Europe and beyond. London may need to come up with some new ways of working for better mental health because of its particular characteristics, but it is a reasonable bet that any ways forward that it identifies will also have some resonance elsewhere. In other words: if we can improve mental health services in London, the whole country stands to benefit.

Each chapter in this report reinforces the need to address the special issues that face London's population and London's mental health services with a whole-city approach, together with local action. London's workforce is particularly transient. Service users cross boundaries of borough and PCT. Housing issues cannot be addressed in a parochial manner. London's solutions must be London-flavoured, and London must be seen as a world city, with all the pluses and minuses that go with that.

A number of detailed suggestions for tackling specific problems are integrated into the MHI working papers. Those suggestions and recommendations are not, on the whole, reproduced here. Readers wishing to look at the topic areas in detail are referred to the working papers themselves (*see* p 173), and to the other sources referenced throughout this report. This chapter sets out a small number of high-level recommendations for ways forward, concentrating on those aspects which need to be taken forward London-wide in order for more detailed work at a local level to succeed.

Specific conclusions and recommendations

Developing a strategic approach for London

As we have seen, many of the themes in this report point to fragmentation and patchy development of mental health services, and to potential solutions that are bigger than individual PCTs or London boroughs. If local efforts are to succeed, they must be rooted in a London-wide mental health strategy. Some of this work was addressed by the (now abolished) London Region, working jointly with users to produce an initial mental health strategy.

We are aware that calling for another strategy can cause an allergic reaction, in clinicians, managers and service users alike. That is probably because so many strategies are top-down, and a top-down strategy is clearly not the answer for London's mental health. Rather, what is needed is a London-wide mental health strategy that is built from the bottom up, reflecting local need, addressing local problems and co-ordinating where co-ordination is required. To some extent, this builds on the approach being taken to arrive at a strategy for secure mental health services for London.

There are a number of ways to build this strategy. Many people in London's health and social community lament the demise of the London Directorate of Health and Social Care (DHSC) and its short-lived predecessor: the London Region. London's DHSC was much needed and clearly made much more sense, geographically and politically, than DHSCs elsewhere in the country. Given a blank sheet of paper, many people would sketch out a body that had an overview of health and social care for the whole of the capital. However, it is not appropriate at this time to call for it to be reinstated, and it is clear that at this juncture there is little appetite for yet more layers of bureaucracy or new organisations to take things forward. Major reorganisation is not an answer.

A pragmatic approach would be to charge the London strategic health authority that has the lead on mental health (currently North West London) to bring together the other strategic health authorities for this purpose, ensuring that they involve key stakeholders properly, including service users and carers, in developing the strategy. Considerable vigilance will be required to ensure that rapid progress is made.

There are a number of existing bodies whose job it is to work for and across London, including:

- **the Greater London Authority**, whose remit extends to a number of areas that impact on London's mental health, and which incorporates the London Health Commission, to drive forward its London health strategy
- **the Government Office for London**, which works with partner organisations throughout London, acting as a bridge between Whitehall and the London community to deliver policies on behalf of the Office of the Deputy Prime Minister, the Department for Transport, the Department for Education and Skills, the Department of Trade and Industry, the Home Office, the Department for Culture, Media and Sport, the Department for Environment, Food and Rural Affairs, and the Department of Work and Pensions
- **the Association of London Government**, which acts partly as a think tank, and partly as a lobbying organisation to get the best deal for London's councils.

What is needed is a London-wide mental health strategy that is built from the bottom up.

It also runs some services on behalf of the London boroughs, including the Freedom Pass and the taxi-card scheme.

It is essential to work with existing London-wide organisations in developing London's mental health strategy and those organisations have much to offer. At the same time, the existence of several different organisations – each with a distinct but overlapping portfolio of interests – can, in itself, slow down action and make co-ordination across the capital quite difficult to achieve in a reasonable time frame.

Recommendations

- ☑ A London mental health strategy should be developed, involving all stakeholders and working in close collaboration with existing London-wide organisations and with relevant voluntary organisations. This strategy would consider the implementation of the National Service Framework for Mental Health across London, as well as the co-ordination of efforts to address those issues that need a London-wide approach (for example, aspects of housing and workforce issues). However, for mental health service provision, the strategy should be built from the bottom to reflect local needs and address local problems.

- ☑ The strategic health authority in London that has the lead on mental health (currently North West London Strategic Health Authority) needs to co-ordinate the development of London's mental health strategy, and the Department of Health must ensure that the effectiveness of this arrangement is kept under review.

- ☑ Central government and strategic health authorities must agree clear arrangements to ensure accountability for the implementation of London's mental health strategy.

Strengthening commissioning in London

Mental health commissioning in London is weak and underdeveloped. It varies in quality from one PCT to the next, and different PCTs devote different levels of time to it. The reality is that the process of commissioning mental health services in London comprises a set of ill-matched dialogues between a small number of large mental health trusts and a much larger number of fairly weak and under-developed PCTs. Some specialised mental health services are commissioned on a lead-commissioner basis, and the model currently used for specialist commissioning could be developed to include most mental health services.

Overall, the picture is one of duplication of effort, with expertise thinly spread. Even allowing for the newness of these commissioning organisations, something must be done to improve mental health commissioning as a matter of urgency.

That is not to suggest that all aspects of commissioning mental health services in London should be wrested from the organisations that currently commission those services. It is important to ensure that London PCTs retain a major interest in the mental health of their local populations – for prevention, health promotion and service development alike. No one is better placed to take a lead on assessing local need than the PCTs and their partners in the local health economies.

However, the nuts and bolts need not be done at a very local level. Detailed work on contracts can certainly be done in a more co-ordinated manner. Discussions and negotiations about new ways of configuring services may also have a greater chance of success where the several PCTs that look to one particular mental health trust work together to commission services. Above all, we need to find ways to retain engagement and ownership at a local level, while developing expertise and commissioning skills at a less local level, in line with a strategic approach for London.

At whatever level commissioning takes place, those who actually work as commissioners in mental health need to be able to access support. A network of London's mental health commissioners has already begun to meet under the aegis of the London Development Centre for Mental Health, and has proved popular. We strongly endorse this approach to supporting commissioning mental health services in London, both for those aspects that should continue to be done at a local level, and for prospective and actual lead mental health commissioners in the future.

Recommendations

- ☑ PCTs, in co-operation with their local authority partners, need to identify a lead PCT in each strategic health authority to undertake those aspects of commissioning that would benefit from sector-wide commissioning.

- ☑ Strategic health authorities must take responsibility for ensuring that lead commissioning arrangements are in place and for resolving disagreements between PCTs on commissioning decisions and priorities.

- ☑ Each PCT, in co-operation with its local authority partners, should retain the responsibility for assessing local needs and ensuring that they are being met, and commissioning small-scale services to meet very specific local needs. However, detailed work on service specifications and the contracting process would best be undertaken by the identified lead commissioner on behalf of the other PCTs in the sector.

- ☑ Given that commissioning is still a new and developing skill, the London Development Centre for Mental Health needs to work with the King's Fund and other developmental and educational bodies to establish a Centre for Excellence in Commissioning as a resource for commissioners.

Advancing performance management

Many of the recommendations outlined in this report can only improve with robust mechanisms for performance management. Calling for effective performance management is hardly the kind of recommendation to excite people. Some people at a local level feel that they are performance-managed to within an inch of their lives as it is. Yet mental health services are evidently not performance-managed as effectively as they could be, since wide gaps in provision and variations in quality and provision that are unrelated to need still persist.

In theory, a variety of mechanisms for improving performance management are possible, but it is important to avoid creating new bodies with performance management functions specifically for mental health. Instead, it would seem

Performance management must be combined with supporting and developing leadership for commissioners and providers of mental health services.

sensible to build on arrangements that are already in place and are beginning to become more effective, and to continue to vest these powers in the strategic health authorities, developing the role of the lead one. This recommendation goes hand-in-hand with developing a London mental health strategy, since progress at a local level will need to be managed within the context strategic aims for London's mental health.

The challenge for developing more effective performance management of London's mental health services is not just a matter of becoming more rigorous. What is needed is the setting of clear standards, with the involvement of service users and carers, together with effective and accessible support to ensure that standards can be met. Performance management must be combined with supporting and developing leadership for commissioners and providers of mental health services. Within these frameworks, peer group support, through networks of mental health commissioners and providers, should also play an important part.

Recommendation

- ☑ Strategic health authorities need to strengthen their performance management of mental health services in London, with an emphasis in achieving equity in relation to need in services across London in the context of a London mental health strategy.

Improving service delivery

There have been a number of significant and positive changes to mental health services since the last King's Fund mental health inquiry. The development of community mental health teams is almost universally regarded as a major step in the right direction. Assertive outreach, early intervention and crisis resolution services are also having a positive impact. The concerns that remain about community-based services are mostly about the uneven development of these services across London, and the extent to which they fall short of meeting need in parts of London.

Certainly, improvements in mental health services delivered by primary care professionals are called for. Skills (nurtured by education and training) are under-developed, and access to counsellors and psychiatrists remains uneven.

However, important concerns remain about how mental health is viewed and understood by the public, and – perhaps even more importantly – by politicians and policy-makers. A disproportionate emphasis on dangerousness and risk has meant that early investment of modernisation monies has been concentrated on secure services. This has inevitably deflected attention from the continuing development of much-needed community services. It may also have diverted attention from developing mental health services in primary care, and from thinking about improving the care given in acute inpatient units for people with severe mental illness whose condition does not pose a threat to others or require secure facilities.

Much has improved, but the balance of care in London is not yet right, and both community-based and hospital-based services stand in need of development. The inquiry has been particularly concerned about the imbalance of services for

Acute wards seem to have suffered from a degree of neglect since 1997. They are often seen as unsafe and unattractive, by service users and staff alike.

people with mental health problems – both serious and less so. It is clear that there are serious shortcomings in the provision of specialist mental health services, but it is also evident that those shortcomings can have a significant knock-on effect in primary care, which in turn is seriously under-developed. It is important that as part of any effort to improve services for people with mental health problems, it will be necessary to look at how all the services fit across the whole system.

Despite continuing high usage of inpatient facilities, acute wards seem to have suffered from a degree of neglect since 1997. They are often seen as unsafe and unattractive, by service users and staff alike. There remains a need to address violence and aggression on the wards, and to get to grips with the challenges posed in London by the very high numbers of people who have a substance misuse problem as well as a mental health problem.

There are some indications that community teams gain at the expense of acute wards: acquiring their most experienced and competent staff, and leaving behind a relatively low proportion of experienced and permanent staff whose numbers are augmented by temporary and less experienced staff. At the same time, the demands made on acute-ward staff have grown, with the increase of dual diagnosis and the higher dependency levels of people who cannot be treated in the community.

London's mental health services have yet to achieve a good enough standard of appropriate and acceptable mental health services for black and minority ethnic communities. In spite of a growing number of examples of excellent and sensitive services, the overall perception of mental health services by black and minority ethnic people has scarcely improved since 1997. Black people are still over-represented as users of mental health services – particularly in inpatient wards, including secure facilities. Often, they see those services as frightening and inappropriate. These problems are well recognised, but solutions remain to be put in place.

Appropriate provision for women also needs further development. All of these issues for black and minority ethnic people, and for women, can be taken forward in the context of improving patient choice.

The contribution of mental health service users to improving services is very significant – and could be even more so, if mental health service users and their organisations were adequately supported and funded.

Other concerns that were mentioned in the course of this inquiry but were not the subject of detailed exploration included mental health services in London's accident and emergency units, and the mental health of prisoners. More work needs to be undertaken on both these issues.

Recommendations

- ☑ Mental health trusts and PCTs in London, together with their local authority partners, need to further develop community services across London, focusing especially on services for which there is good evidence of effectiveness.

- ☑ The National Institute for Mental Health in England, through the London Development Centre for Mental Health, must work with other relevant organisations to improve support for providers of mental health services in London and to facilitate access to support and development, especially for those in a leadership role in mental health.

- ☑ Mental health trusts need to review conditions, staffing levels and skill mix in acute inpatient wards, instigating measures to improve the status, rewards and support for ward staff, and to improve the ethos of acute wards for the benefit of staff and service users alike. This is especially important where the incidence of co-morbidity and dual diagnosis among service users makes providing safe and effective services most challenging.

- ☑ Mental health trusts must prioritise training on dual diagnosis and complex needs for staff in London's acute inpatient wards.

- ☑ To complement local work on improving acute care, central government should commission an independent, systematic review of acute inpatient care provided for black and minority ethnic service users, to address concerns about safety and appropriateness.

- ☑ Mental health trusts and PCTs, in co-operation with their local authority partners, need to take urgent action to commission and provide a range of services to meet specific needs of black and minority ethnic service users, especially women.

- ☑ Mental health trusts, PCTs and their local authority partners should work more closely with service users and carers and their organisations, which must be empowered to play a major part in making change happen. Their progress in doing so should be scrutinised by the Commission for Healthcare Audit and Inspection (CHAI) in the course of its reviews.

- ☑ Mental health trusts need to extend opportunities for shared learning between acute inpatient staff, staff in community mental health teams, and staff in assertive outreach and crisis services.

- ☑ The appropriate royal colleges, workforce development confederations (and strategic health authorities, when they assume responsibility for the work of workforce development confederations in 2004), and other bodies responsible for the education and training of primary care professionals must ensure that primary care professionals are better trained, resourced and supported to offer high quality care to people with mental health problems. This should include those with less serious mental health problems who use primary care but are often seen as less of a priority by specialist services.

- ☑ PCTs and strategic health authorities must recognise primary care mental health services as an essential part of the range of services for people with mental health problems, alongside specialist mental health services.

- ☑ PCTs need to identify a budget for primary care mental health services, to support the implementation of the NSF and NHS Plan targets.

Tackling the housing need

Of all the issues facing people with mental health problems, the need for housing is one of the most fundamental. For some people, it is simply a matter of housing need. Others require varying levels of support, as well as housing, in order to live as full a life as possible. This may include receiving help in maintaining their housing tenure.

The period since the 1997 report has been one of change, particularly in that the wishes and preferences of people who have developed mental health problems during the past few years are different from those of an earlier generation. The enormous challenge of resettling long-stay patients from the old institutions is now receding into history. In the 21st century, people with mental health problems are more usually treated in the community, and when they require hospitalisation, the emphasis is on returning them to the community as soon as possible.

This means that the biggest areas of need are for ordinary housing, and for housing with some support services offered. People naturally want their own front door rather than group homes, and they do not necessarily wish to live in a specialised facility in order to access support. People also want continuity and security in housing and support. Hostels that require people to move on do not offer that, and although they meet the needs of some people very well, most people would probably prefer more permanent housing with varying levels of support that increases or decreases as necessary.

At the same time, some of the needs of Londoners are becoming ever-more complex. Those with alcohol or substance misuse problems in addition to their mental health problems – widely thought to be an increasing number – may need a high level of support, and may find it difficult to maintain tenancies.

The provision of social housing is very important for people with mental health-related needs, but overall there has been a slight decline in provision relative to the needs of the population, and there are great variations in provision across London.

The development of the Supporting People programme is welcome and positive, but much remains to be done to agree provider priorities in offering specialist accommodation and appropriate support, and to ensure that funding from Supporting People, health and social services is co-ordinated, and is sufficient.

In spite of all the information that is available, there are gaps in information, and there is a great need of a London-wide approach to data collection.

Those with alcohol or substance misuse problems in addition to their mental health problems may need a high level of support.

Recommendations

- ☑ Local authorities, in co-operation with PCTs, need to undertake strategic assessments of local needs, taking into account shortfalls in provision and shortcomings of existing accommodation and service models, as well as the needs of people with dual diagnosis and complex needs.
- ☑ The Office of the Deputy Prime Minister (ODPM) must work with key London-wide statutory and voluntary organisations to agree an action plan for housing

for people with mental health needs in London. This would include ordinary, permanent housing for people with mental health needs.

- ☑ Local authorities and other housing providers must work with black and minority ethnic communities and agencies to develop models of good practice in meeting the housing needs of mental health service users from those groups, across London.

- ☑ The Department of Health and the ODPM should work together to introduce a single database of mental health provision in London incorporating the new Supporting People database, registered care, and other health and social services provision. This should be used to develop mental health and housing strategies to feed into future Supporting People planning.

- ☑ Local authorities and housing providers need to do more work on ways to help mental health service users find and keep suitable housing. The Social Exclusion Unit could usefully consider housing for mental health service users as a factor affecting employment in its forthcoming work on mental health and social exclusion.

- ☑ The Housing Corporation, housing associations and Supporting People teams should gather and publish models of good-practice approach that combine the provision of housing and support for people with mental health needs with affordable housing for key workers.

Promoting mental health

Throughout this inquiry, there was little dissent from the principle of trying to reduce the amount and severity of mental health problems in London, and to minimise the effects that mental health problems can have on people's lives. However, we found that there was a lack of consensus on what promoting mental health or preventing mental health problems meant, and little agreement on which activities and initiatives would contribute to better mental health and how to evaluate their effectiveness.

In addition, public policies did not always promote mental health – for example, in dispersing asylum seekers to parts of the country where they were isolated from community networks and support. This points to a need for more courageous leadership from government, to promote better understanding of what improves, or adversely affects, the public's mental health.

The 2003 King's Fund inquiry heard of many community development and regeneration initiatives that may directly or indirectly improve mental health. A greater focus within these initiatives on the needs of mental health service users would be most welcome. Although a detailed study of employment issues was not part of the scope of this inquiry, this is widely recognised to be a major problem for mental health service users. Opportunities for employing mental health service users could be developed as part of regeneration schemes aimed at bringing people into the labour market.

In addition, the inquiry has highlighted the importance of good housing for people with mental health problems, and its importance in underpinning their recovery and rehabilitation.

The importance of involving service users and the public in health and social care has been noted throughout this report.

The importance of involving service users and the public in health and social care has been noted throughout this report. As well as improving individual patient choice and helping to shape more responsive services, involving people is a part of building healthier communities. Capacity building in voluntary organisations – and in particular, in small user-led organisations and black and minority ethnic organisations – is essential.

Recommendations

- ☑ The Health Development Agency needs to work together with relevant bodies to agree on a definition of mental health promotion, and to indicate which approaches, interventions and activities should be developed, so they can be costed and evaluated properly.

- ☑ NHS bodies, local authorities and other relevant public bodies should assess emerging new policies at the development stage, to avoid social exclusion and other possible negative effects on the mental health of communities.

- ☑ Local strategic partnerships must ensure that neighbourhood renewal and regeneration programmes contribute as fully as possible to improving the mental health of communities.

- ☑ The royal colleges and universities, alongside other educational establishments responsible for the education and accreditation of training of health and social care professionals, should provide education and training on mental health promotion. This would sit alongside more conventional courses on providing care to people with mental health problems.

- ☑ Central government, NHS bodies and local authorities need to recognise the important contribution of voluntary organisations in promoting mental health, and should identify a range of measures, including capacity building and more secure funding, to enable them to develop this aspect of their role.

- ☑ Local implementation teams must ensure that they have appropriate and strong stakeholder involvement that will enable them to deliver better mental health in local communities.

Addressing finance

The King's Fund mental health inquiry commissioned a considerable amount of research in order to answer key questions about the adequacy, distribution and use of money for London's mental health services. In particular, it sought to understand how the current situation compared to that of 1997. There is a strong indication that NHS spending on mental health has increased gradually, but on a modest scale, and across London there are wide variations in spending – only some of which can be explained by socio-demographic factors.

Although London has a higher mental health spend than other parts of the country, this is unsurprising given the levels of need in the capital, and it cannot be assumed that London's mental health services are adequately funded.

Given the large amounts of money involved, it is a matter of public concern that it was not always possible to find out what had happened to monies specifically

allocated for mental health – a point that leads to a wider issue about improving data and information on mental health services in London.

Recommendations

- ☑ The Department of Health and primary care trusts must develop a better and more transparent system for tracking the use of funds intended for mental health, ensuring that they are targeted at assessed needs and are not used to set against deficits in other services. The system must allow valid comparisons to be made across PCTs.

- ☑ Strategic health authorities, with the help of PCTs and their local authority partners, need to examine the reasons for the variations in spending across London on mental health, and consider whether they need to make changes so they can invest in services for which there is a need and evidence of effectiveness.

- ☑ The Audit Commission should examine levels of expenditure on mental health as part of its reviews of PCTs and mental health trusts.

Making data and information available

The paradox about data on London's mental health and mental health services is that while there is so much information available on some aspects, it is not always easy to locate what there is, identify gaps, and make sense of the incomplete findings that are available. Sometimes, official information on service activity in London simply does not accord with local knowledge. For example, in some areas there are real gaps in knowledge about the use of funds allocated for mental health.

In particular, we support the concerns of the Audit Commission (2003) about the lack of a requirement for trusts to record in a standard way how monies for specific purposes are spent.

Recommendation

- ☑ Central government, in co-operation with the strategic health authorities, should take stock of what information is available, and should state what information is required about mental health services and spending – in particular, scrutinising how it is collected and presented in relation to how it will be used. Data should be collected in a way that enables comparisons across London, and in relation to other parts of the country. There needs to be a clear audit trail for the use of funds intended for mental health.

Meeting the workforce challenges

The health and social care workforce – and the mental health workforce in particular – faces challenges across the whole country, but this is even more the case in London. This is because of three factors:

- the size and complexity of the workload
- the nature of London's workforce
- the expense of living in London, which results in problems for the workforce in acquiring affordable housing.

London's specific problems need a creative approach over and above the usual initiatives to support recruitment and retention.

London's specific problems need a creative approach over and above the usual initiatives to support recruitment and retention. Improving the retention of skilled and qualified staff must be one objective of any mental health service. But in addition to this, London has to come to terms with the inevitability that its mental health workforce will continue to include a high number of people who will spend some part, but not all, of their career in London. As we have seen, this implies a different skill mix and excellent leadership at team manager and ward manager level.

There are particular concerns about the pressures on the workforce in acute inpatient services and the extent to which their status has fallen as new community-based teams are formed, and the wards lose staff to areas of the service that are seen as more exciting or rewarding – or possibly, less stressful.

While there are shortages in a number of mental health professions, there are also talents that are not put to full use. Refugees who have relevant experience or qualifications in mental health should be supported and encouraged to work in London's mental health services. Mental health service users should also be supported and encouraged wherever possible to take up employment opportunities in the service.

Recommendations

- ☑ The workforce development confederations (and strategic health authorities, when they assume responsibility for the work of the confederations in 2004) need to work together to develop a strategy for action to address the challenges facing London's mental health services. This should link in to the London-wide mental health strategy, recommended earlier in this chapter.

- ☑ The workforce development confederations (and strategic health authorities) need to take responsibility for compiling robust data specifically relating to the mental health workforce in London. A minimum dataset to inform the routine and mandatory collection of workforce data across the specialties should be introduced as a matter of urgency.

- ☑ A named person in each workforce development confederation (and in the strategic health authorities) should take responsibility for helping refugee workers to enter the workforce in mental health and other services.

- ☑ A named person in each workforce development confederation (and in the strategic health authorities) should take responsibility for increasing the recruitment and retention of mental health service users as workers in London's mental health services.

- ☑ Mental health trusts should review the pressures on the workforce on acute wards, with a view to better training and support for that section of the workforce.

- ☑ Workforce development confederations (and strategic health authorities) should co-ordinate the collation and dissemination of good practice in recruiting and retaining staff and, liaising with mental health trusts and the London NHS human resources managers' network, should provide development opportunities for all trusts to learn from the experiences of the most successful trusts.

Ultimately, it is the experience of the service user that lies at the heart of any measure of success in developing London's mental health services.

Ways forward

This report is not an end, but a beginning. The serious work of turning the report's recommendations into the reality of better services and outcomes for people who use mental health services starts here.

These recommendations involve a wide range of organisations, not all of which specialise in mental health. They impact on government departments, strategic health authorities, primary care trusts, mental health trusts, NIMHE, the London Development Centre for Mental Health, workforce development confederations, CHAI, the royal colleges, voluntary sector organisations, local authorities, housing agencies, employment agencies and others. We recognise that every one of these organisations already has a very full agenda. But it is vital that space is made on that agenda to push forward continuing and sustainable mental health improvements.

The King's Fund expects to play a full part in working with agencies and organisations across London in taking this work forward, and we will be committing resources to facilitate the process. Some of these may be targeted at partnership working, others may involve brokering local discussions between organisations, and some may be used to establish local schemes and disseminate good practice.

Ultimately, it is the experience of the service user that lies at the heart of any measure of success in developing London's mental health services. As this inquiry has demonstrated, in the past five years the challenges have not substantially changed, while the availability and quality of services remain mixed, and positive progress has been slow. We need to push forward now, to ensure that in another five years' time, the experiences of people who use London's mental health services will be much better than they are now.

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