EDITORIAL

'Gentlemen, we have no money therefore we must think'† – mental health services in hard times

Frank Holloway[1]

The Psychiatrist (2011), **35**, 81–83, doi: 10.1192/pb.bp.110.030627

[1]c/o The Psychiatrist, The Royal College of Psychiatrists, London

Correspondence to Frank Holloway (frank.1.holloway@kcl.ac.uk)

First received 23 Jul 2010, final revision 20 Oct 2010, accepted 6 Jan 2011

Summary In common with all elements of public services, mental healthcare in England faces a troubling and uncertain future. Two things, however, are certain: demographic trends ensure that demand will rise and harsh economic realities dictate that resources will in real terms shrink. In order to cope with these challenges, commissioners and providers will have to review very critically all aspects of the mental health system, including those that are currently fashionable. There is a need to identify and promote activities that are evidence-based and effective and to jettison practices and services that lack an evidence base.

Declaration of interest None.

Mental health services in the UK face enormous challenges as a result of the financial crisis that has affected all advanced economies since 2008. This has hit the UK particularly hard because of a large structural deficit in the public finances (tax does not currently raise what the government spends). These challenges represent a 'perfect storm' for health and social care.[1] Policy makers, managers, practitioners, service users, carers and the general public must look critically at what mental health services currently do and make hard choices as to whether less is done, whether what is currently done can be done more cheaply, whether different and more effective activities are undertaken or whether in these straitened times a societal 'invest-to-save' bid can be made to divert scarce resources into mental healthcare.

All parties in the last UK election in May 2010 pledged to maintain health spending 'in real terms' (i.e. taking inflation into account) despite the massive imbalance in UK public finances, and this commitment was retained by the government as it came into office. The devil here is in the detail, because inflation in the healthcare sector is always higher than general inflation. Additionally, social care and social welfare spending is not to be protected from cuts. This will have a profound effect on all healthcare economies – disproportionately on mental health services, which are integrated in terms of health and social care and depend greatly on the infrastructure of social care to function effectively.

Health policy and spending is devolved to the four UK administrations (England, Scotland, Wales and Northern Ireland). There are significant divergences between jurisdictions in terms of spending and mental health policy: per capita spending is less and community mental healthcare is more advanced in England (no causal relationship is implied). This paper is written from the perspective of practice and policy in England and focuses on the threats and opportunities for adult mental health services. Demographic changes and potential disinvestment in social care suggest that old age mental health services face even more challenging times than adult mental health services.

Spending on the National Health Service (NHS) in England has increased dramatically over the past decade: at 2008 prices it rose from £59 billion in 1998/1999 to £102 billion in 2007/2008.[2] Before the election £20 billion of 'efficiency savings' from the existing NHS budget were being demanded by Sir David Nicholson, NHS England Chief Executive, over a 5-year period. The incoming Secretary of State for Health, Andrew Lansley, predicted that the savings targets may need to be greater than this, given the underlying increase in demand for healthcare and implicitly the impossibility of injecting more cash into the NHS. This admission has both been hailed as refreshingly honest and condemned as extremely worrying.[3]

Where are we now?

We entered the 'perfect storm' in rather good shape. Adult mental health and social care in England experienced a 50% real-terms increase in investment between 2001/2002 and 2008/2009 to £5.9 billion, of which 83% was commissioned by the NHS and 69% was provided by it.[4] Despite manifold shortcomings, mental health services in England are better funded and better organised than services in almost all European countries.[5] Psychiatric bed numbers have reduced steadily since a peak in 1955 to levels well below the average for advanced industrial economies.[6]

Following *The NHS Plan* of 2000,[7] a centrally mandated structure for adult mental health services has resulted in a complex service system that includes

†Attributed to Ernest Rutheford.

single-gender in-patient accommodation, a plethora of community mental health teams (primary care liaison/community mental health, assertive outreach, early onset psychosis, crisis resolution/home treatment), dedicated personality disorder services, and specialist services focusing on social inclusion.[8–11] Massive investment has been provided for the Improving Access to Psychological Therapies (IAPT) programme.[12] New roles have been developed to supplement the traditional mental health professions – these include gateway workers, support time and recovery workers and primary care psychological therapy workers. The National Institute for Health and Clinical Excellence (NICE) has provided guidelines on almost every aspect of mental healthcare, making explicit expectations on the provision of evidence-based (and sometimes not-so-evidence-based) treatment and care.

But we enter these difficult times with some other, possibly less welcome, baggage. Society is in general risk averse and mental health services have become increasingly drawn into an agenda of reducing bad outcomes (notably violence thought to be associated with mental illness, suicide and substance misuse-related crime) as opposed to promoting good outcomes (symptom reduction and improved social outcomes). There is an explicit policy of diverting people from the criminal justice system into mental healthcare.[13] This is worrying on a number of levels – not least because although we have steadily reduced psychiatric bed numbers, the prison population, which has a very high prevalence of mental disorder (particularly substance misuse and personality disorder), has expanded enormously. An ever-increasing proportion of the adult mental health budget is now devoted to rather small numbers of people who end up in conditions of security – from 12% of the direct care budget in 2003 to 19% in 2009.[4] The Mental Health Act 1983 (revised 2007) provided a (very deliberately) broad definition of mental disorder – this may lead to a situation where in-patient mental health services become the repository of people with untreatable paraphilias, something that is now a feature of the US state mental hospital system.[14]

In the UK, we have a highly complex regulatory system for mental health services: managers have multiple beasts to feed, which include the Care Quality Commission, Monitor (the regulator for NHS foundation trusts) and the NHS Litigation Authority. The National Patient Safety Agency and NICE tell us what to do, though not always in ways that promote clinical wisdom and best practice. When we err as doctors we are accountable to our professional regulator – the General Medical Council – and may be brought back into practice through the offices of the National Clinical Assessment Service.

'Feeding the beast' is not only a major preoccupation for managers, it involves a great deal of front-line activity that has little obvious relevance to practitioners (who also have to spend ever-increasing time undergoing the mandatory training required by the regulators). There is also a separate set of reporting requirements for the social care aspect of the work of integrated mental health teams that, despite the ultimate destination being the Department of Health, is in no way joined up with the 'health' reporting requirements.

The expected introduction of the payment by results regime into mental healthcare will, if implemented, require additional activity by staff to cluster their patients/clients and provide regular reporting of outcome measures.[15] There are other policy-related pressures on services: the introduction of the European Working Time Directive has made duty rotas for medical staff ever more expensive and complex. Reforms to medical training seem to have, bizarrely, impeded the flow of high-quality doctors coming into psychiatric training (which at the same time becomes increasingly onerous for trainers to deliver).

Where does the money go?

Spending on adult mental health services has been subjected to annual mapping carried out by Mental Health Strategies, a specialised management consultancy. In the latest financial mapping exercise,[4] reflecting spending in the financial year 2008/2009, the single largest item was secure and high-dependency provision (19% of the direct costs), followed by generic community mental health teams (14%), acute in-patient services (13%), continuing (hospital) care (12%) and specialist housing and residential care (9%). The new functional teams introduced in the *NHS Plan* together accounted for approximately 9% of direct costs. However, a substantial amount of health and social care spending goes on 'indirect costs', 'overheads' and capital charges – 19% of the total spend. One striking finding from this set of data is how much money is spent on bed-based services despite over 50 years of deinstitutionalisation.

What to do?

Readers will be painfully aware of the hard financial choices that have to be made within mental health services. One useful yardstick is to measure the expenditure (of money, staff time, etc.) on x with the gains that would flow from spending the money on y (what economists call the opportunity cost of a decision). This can be viewed at the macro level – what we gain from whole streams of activity – and at the micro level – for example, spending money on (expensive) psychiatrists and psychologists rather than (cheaper) support, time and recovery workers. However, cheaper does not necessarily mean more efficient.

It is inevitable that all services will look critically at what they do to see whether the activity is not essential (in which case it may be stopped) or can be delivered more efficiently. Local and national politics have a part to play in decision-making – popular or fashionable services may be harder to cut than unpopular or unfashionable ones. (The planned introduction of general practitioner (GP) consortia as the vehicle for commissioning services introduces a further unpredictable element to decision-making.) Where services have a rather poor evidence base they are highly vulnerable. Currently many trusts are disinvesting in assertive outreach teams in the belief that the function can be delivered more cost-effectively through good-quality community mental health teams. Other innovative services, particularly IAPT, specialist personality disorder services and the new social inclusion services, will be scrutinised

https://doi.org/10.1192/pb.bp.110.030627 Published online by Cambridge University Press

very critically to see whether the promised outcomes are delivered. There is a real imperative to challenge the seemingly unstoppable rise in the use of secure care and to ensure that when it is used the system is driven effectively.[16] Traditional ways of working will be challenged and complexity in the service system, which inevitably raises transaction costs, should be stripped out. Cheaper ways of providing continuing care will be sought, possibly through low-intensity services (actually rather traditional), possibly through more use of shared-care arrangements with GPs. A sharper focus on the 'revolving-door' patients might lead to the elaboration of more effective treatment plans that might include electively longer stays in rehabilitation-focused in-patient units.[17] Care packages and care pathways may in principle focus the minds of providers, patients and carers on what services will actually offer.

Potential sources of saving that are unlikely to find favour would be a very thorough pruning to the regulatory framework surrounding mental healthcare (so that managers can get on with managing rather than feeding the beast), abandonment of payment by results (with its very large transaction costs), reassessment of the whole unscientific risk assessment industry and a review of the mandatory training our regulators insist we go on. On a more fundamental basis, the remit of mental health services should be focused much more clearly than is currently the case on the assessment, treatment and care of people with mental illnesses. It is for politicians to create the circumstances that allow the nation's social capital to increase, not psychiatrists and psychologists.

What not to do

There are also some things not to do: I have three. The first is not to engage in salami slicing services year on year to meet savings targets: much more root-and-branch changes will be required than can be accommodated by shaving a post here and there. The second is not to equate good care with ever-decreasing lengths of in-patient stay, something that is an article of faith among trust chief executives. Systems that have deinstitutionalised more aggressively than England, such as Australia, are beginning to regret the consequences of ultra-short in-patient episodes that cannot be definitively therapeutic.[18] The third is not to precipitate disinvestment in mental health services research: we need to continue with high-quality basic and applied research so that our treatment technologies and systems of care can become more effective than they currently are.

Conclusions

These are very difficult times for mental health services. Practitioners, service managers and policy makers will need to make tough decisions. Prioritisation, rationalisation and innovation will all be required if unintended adverse consequences for patients and carers are to be avoided.

About the author

Frank Holloway retired from the NHS in July 2010.

References

1 Harvey S, Liddell A, McMahon L. *Windmill 2009: NHS Response to the Financial Storm*. King's Fund, 2009.

2 Thompson G. *NHS Expenditure in England*. Library of the House of Commons, 2009 (http://www.nhshistory.net/parlymoneypapter.pdf).

3 Ramesh R. NHS cuts may be deeper than expected, warns Lansley. *Guardian* 2010; 14 May.

4 Mental Health Strategies. *2008/09 National Survey of Investment in Adult Mental Health Services*. Mental Health Strategies, 2009 (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103198.pdf).

5 Appleby L. *Mental Health Ten Years On: Progress on Mental Health Care Reform*. Department of Health, 2007 (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074235.pdf).

6 World Health Organization. *Mental Health Atlas 2005*. WHO, 2005.

7 Department of Health. *The NHS Plan: A Plan for Investment, A Plan for Reform*. Department of Health, 2000.

8 Department of Health. *Mental Health Policy Implementation Guide*. Department of Health, 2001.

9 Department of Health. *Mental Health Policy Implementation Guide: Support, Time and Recovery (STR) Workers*. Department of Health, 2003.

10 Department of Health. *Mental Health Policy Implementation Guide: Community Development Workers for Black and Minority Ethnic Communities. Interim Guidance*. Department of Health, 2004.

11 National Institute for Mental Health in England. *Personality Disorder: No Longer a Diagnosis of Exclusion*. Department of Health, 2003.

12 Department of Health. *Improving Access to Psychological Therapies Implementation Plan: National Guidelines for Regional Delivery*. Department of Health, 2010.

13 Appleby L. Offender health: the next frontier. *Psychiatrist* 2010; **34**: 409–10.

14 Hepburn BM, Sederer LI. The state hospital. In *Textbook of Hospital Psychiatry* (eds SS Sharfstein, FB Dickerson, JM Oldham): 197–210. APA Press, 2009.

15 Department of Health. *Practical Guide for Preparing for Mental Health Payment by Results*. Department of Health, 2010.

16 Wolfson P, Holloway F, Killaspy H (eds) *Enabling Recovery for People with Complex Mental Health Needs: A Template for Rehabilitation Services (Faculty Report FR/RS/1)*. Royal College of Psychiatrists, 2009.

17 Holloway F. Rehabilitation psychiatry in an era of austerity. *J Ment Health* 2010; **19**: 1–7.

18 The Senate Select Committee on Mental Health. Inpatient and crisis services. In *A National Approach to Mental Health – From Crisis to Community. First Report*: 183–210. Senate Printing Unit, Canberra, 2006 (http://www.aph.gov.au/Senate/committee/mentalhealth_ctte/report/report.pdf).

https://doi.org/10.1192/pb.bp.110.030627 Published online by Cambridge University Press