BETTER MENTAL HEALTH SERVICES

An Alliance for Quality in London

The Care Gap

An analysis of the condition of mental health services in London and the tasks facing the new NHS London Regional Office

Researched for UNISON Greater London
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Briefing paper presented to a one-day conference **"Better Mental Health Services, An Alliance for Quality"**, organised by UNISON Greater London Region on Thursday May 27, 1999.

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FOREWORD

By Godfry Eastwood, Head of Health, UNISON Greater London Region

Perhaps the biggest challenge confronting the new Labour government in its efforts to reorganise and develop health services in London has been the chronic run-down and neglect of mental health services in the capital which it inherited in 1997.

UNISON charted the scale of these problems in a major report ***The Credibility Gap***, published the run-up to the election, which took stock of the glaring gap between the government rhetoric of "community care" and the grim reality of chaotic, under-resourced services which were completely unable to cope with the levels of demand for mental health care in what is Europe's largest city.

We warned then of the consequences of Tory government policies which had led to the closure of large hospitals and 57 percent of adult long-stay psychiatric beds in just five years without ensuring an adequate infrastructure of community-based services was established to take their place.

We showed that London's NHS needed extra capital investment plus an extra £60m a year – ten percent of the mental health budget – to bridge the gap in provision for adults with long term and severe mental illness.

We welcome the fact that the new government has from the outset repeatedly stressed its intentions to change the situation, to redress long-standing failures, and to "modernise mental health services".

Two years later this report is our attempt to measure how successful ministers and managers have been in achieving the promised changes.

We note some significant steps forward. London now has its own NHS Regional Office, whose mental health team has committed itself to drawing up a pan-London plan by the end of the year and – perhaps significantly – setting out to involve service users in this process. However the additional cash so far available (£6m in 1999/2000, just 1% of London's mental health budget), is too small to resolve the deeper problems. The Regional Office, lacking any democratic mandate or accountability to Londoners, falls short of the Regional Health Authority which UNISON had called for: it also has yet to prove that it can exert any real control over financially-troubled Trusts and health authorities, let alone local government.

The wasteful market system has been scrapped, and there is a drive to merge mental health Trusts into ever-larger units. While UNISON welcomes the cutting of red tape and costs of bureaucracy, we await to see if the new mega-Trusts in South East and West London measure up to their promised improvements in performance, and deliver the improved conditions which are needed to raise staffing levels and fill chronic vacancies.

But on the down-side, as this Report shows, the grim legacy bequeathed by the Tories is still more influential in the reality of mental health care in London than any of the new government's policy initiatives.

The chronic shortage of psychiatric beds, producing occupancy levels soaring above 100%, is largely unresolved. Largely because of this, around £50m a year is still being pumped out of London's NHS to fund private placements of "overspill" patients. The oft-discussed "24 hour nursed beds" remain in desperately short supply throughout London … the list goes on. There is much to be done.

Around £50m a year is still being pumped out of London's NHS to fund private placements

This report does not just list problems. It also sets out some suggestions, in the form of UNISON's Mental Health Workers Charter, developed in the course of a series of discussions over two years involving UNISON's nursing members, user groups and campaigners.

Our Conference ***Better Mental Health Services, An Alliance for Quality in London***, on May 27 will be a unique gathering of front-line medical, nursing and other professional health workers, various mental health service user groups, social service staff, and senior managers from health authorities and the London Regional Office. We hope lessons will be learned and horizons widened as they exchange views on the current problems.

While UNISON naturally seeks to improve the conditions and pay of its members working in mental health, in this conference and Report we are looking wider, to the development of a genuine alliance for quality in mental health, in which the unions have a vital part to play. If we can open up new, ongoing discussion along these lines at all levels of the NHS, the two years of work on this project will have been worthwile.

Executive summary

■ While many things appear to have changed in London's mental health service over the last two years, notably the first moves towards a London-wide strategy for developing services, many of the old problems remain. The type of care – and whether any care is available to any but the most severely disturbed – still varies enormously between health districts and boroughs, with cash pressures often more influential than health needs.

■ However some new policies – notably the possibility of compulsory treatment orders, and the proposal to detain people with severe personality disorders who have committed no crime – could potentially destabilise existing community and hospital services, and impose substantial new costs on health authorities and mental health Trusts. There is great uncertainty over the wisdom of entrusting more control over mental health services to GPs through Primary Care Groups and Primary Care Trusts, given the lack of any evidence that London's GPs wish to add this area of care to their list of responsibilities.

■ A question mark hangs over the effectiveness of the new London Regional Office, and of the various new "partnership" bodies which might be expected to play a role in coordinating and developing mental health care across the capital.

■ Since 1982 London has lost almost 60 percent of its psychiatric beds, while numbers of in-patient episodes have increased. Each bed now treats an average of almost 6 patients each year, compared with just 2 patients per bed per year 15 years ago.

■ The closures of the big Victorian asylums needed to run hand in hand with the establishment of a new infrastructure of community based services, 24-hour nursed accommodation, and sufficient acute psychiatric beds on smaller sites. This generally did not happen.

■ The biggest proportional reduction in beds has been for "adult long stay" patients. By 1996 the last government had admitted that there was a "gap" in care for the "new long stay" patients for whom there was now no appropriate service.

■ Estimates of the scale of this problem in London suggest a shortfall of at least 1,500 places in 24-hour nursed accommodation. To fill this gap would cost £70m in capital and £60m a year for 3,250 extra staff.

■ Repeated surveys have found that this provision of long-term care is the key to lifting the pressure on acute wards: but no significant ne money has yet been made available to bridge this gap.

■ Pressures on acute services have continued to increase, forcing occupancy levels well above 100% in most of London. Services are generally seen to be "well below a minimal safety level".

■ Despite an expansion in numbers of secure beds, London's health authorities are still spending millions on private secure placements of mentally disordered offenders. The costs of this are only partly covered by government funding.

■ There are no centrally available figures, but it appears that the bill for private placements of "overspill" patients for whom there is no bed in London is costing the capital's NHS upwards of £50m a year – for care which NHS consultants warn is often of questionable quality. This cash is siphoned out of the system is not available to fund local NHS services. In SE London 20 percent of all mental health admissions now over-spill into private beds.

■ Community services across London are uneven in their provision, staffing and policies.

■ The huge pressures on London's mental health services flow from its unique levels of social and economic complexity and inequality.

■ Resources for both health service and social service provision vary wildly between different apparently similar districts and boroughs, making the provision of care a lottery.

■ There has been some encouraging investment in assertive outreach services, sufficient to show that in conjunction with adequate acute beds and suitable accommodation it should be possible to minimise the numbers of patients admitted to hospital.

■ Despite reams of rhetoric, few health authorities in practice model their plans on the wishes and needs of patients or their relatives and carers. There is no doubt that users' experience of the current service should be a valuable resource in tackling chronic problems.

■ The chaos, pressure and under-funding of London's mental health services serve to demoralise and de-skill nursing and medical staff. Staff shortages on wards and impossibly high caseloads for CPNs in the community stand in the way of any development of high quality mental health care. The effectiveness of nurse training in preparing staff for the realities of today's mental health service is highly questionable.

The Care Gap

A report on the condition of mental health services in the capital, and the strategic tasks to be confronted by the new NHS London Regional Office in the development of services for the next decade. Researched for UNISON London Region by John Lister of London Health Emergency.

Introduction

Much appears to have changed in London's mental health services since the publication of UNISON's interim report ***The Credibility Gap*** in April 1997, and the change of government the following month. But many of the old problems left behind by the outgoing government persist, and will require decisive and coordinated action if they are to be solved.

On the face of it, there have already been many important steps forward:

● UNISON's call for a London-wide strategic body – a regional health authority – to oversee the development of services, and able to deploy additional resources, has been partly met by the establishment of a London Regional Office. Although it is an appointed body, with no representation from London's resident communities, and holding no meetings in public, this new body does appear to offer a chance to plan and monitor services throughout the capital – for the first time since the NHS was formed in 1948.

● The new government has repeatedly stressed that it regards mental health services as a priority, launched a stream of initiatives, and published a number of documents culminating in the White Paper ***Modernising Mental Health Services***, which also carried a pledge to invest an additional £700m in mental health services nationally over the three years to 2002.[1]

● In line with this, the London Regional Office in its ***Modernisation Plan for the NHS in London*** early in 1999 promised to begin work immediately on a mental health strategy for the capital, and to hold a conference to discuss the strategy and a "framework for action on mental health" in November 1999. [2]

● There have also been organisational steps which attempt to eliminate some of the fragmentation of services – stemming from the last government's market reforms – which made London-wide planning even more complex. Mergers of mental health Trusts in South East London and West London, together with other policy changes, have reduced the number of NHS Trusts delivering mental health services from 27 to 20, with just four Trusts now responsible for mental health services in the whole of South London. The merger process looks set to continue, with discussions now taking place on the reconfiguration of services in outer west London, East London, and outer North East London, which could reduce the number of Trusts by as many as five.

● Extra money and resources have been promised for mental health care in the capital, with the London Regional Office pledging to invest an additional £6m to provide

Mergers have reduced the number of NHS Trusts delivering mental health services in London from 27 to 20.

additional community teams and front-line beds in 1999/00.

However, much of the good news is slightly premature. Most of these generally positive changes have yet to take effect or prove themselves effective. Resources are still inadequate to the tasks required. Despite the fine words and worthy aspirations in recent policy documents, London's mental health services remain largely as they were left by the Tory government two years ago:

● With few exceptions, service users in much of London are still being offered little more than an arbitrary mish-mash of poorly-coordinated and over-stretched services, in which the level and quality of care a patient receives is a lottery, dependent on where they first seek treatment.

● The level and shape of services is largely dictated by NHS policy decisions taken 10-20 years ago, which have led to a massive and rapid reduction of available hospital beds without ensuring the necessary expansion of alternative, supportive services in the community.

● Almost 60 percent of the adult long-stay beds have closed in London's psychiatric hospitals since 1991. These closures are continuing. Yet even the last government was obliged to admit that this had left thousands of people with chronic and severe mental health problems either to fend for themselves or, in many cases, to occupy inappropriate beds on crowded, dangerous acute psychiatric wards.

● The combination of policy and financial pressure has also left London's mental health services desperately short of the acute beds Trusts might reasonably expect to have available. A major report last autumn, ***The Health of Londoners***, drew attention to a shortfall of almost 800 acute mental health beds in the capital, if the level of actual provision is compared with the Mental Illness Needs Index.[3]

● With many of the inadequate number of acute beds filled by patients with chronic conditions who would be better treated elsewhere, it is little surprise that so many of London's front-line beds are running at or above 100 percent occupancy. Department of Health figures show that 17 out of 27 mental health Trusts averaged acute bed occupancy of 98 percent or above throughout 1997/98, while only three averaged below 90 percent[4]: many Trusts at peak times during the year hit figures well above 100 percent. More recent figures collected for this report show that these problems continue unabated.

● The lack of NHS psychiatric beds in London has led to a constant stream of patients being sent elsewhere for in-patient treatment. Some go to NHS hospitals outside the capital, others to private hospitals in and beyond London, some of which appear to deliver a questionable quality of care, and pose real problems in coordinating the appropriate arrangements for discharge.

In either case, the result is to siphon scarce cash resources out of London's NHS, intensifying the squeeze on front-line care, and limiting the scope to invest in improved local services.

● Reports since 1996 have emphasised the impact on front-line acute psychiatric wards of London's desperate shortage of 24-hour nursed accommodation for those with long-term and severe mental illness. In 1997 there was a three-fold variation in the provision of these facilities across London. Local authorities which might have been expected to play a role in the provision of these places have in the main not done

Government mental health policies 1954-99

1954	Run-down of the Victorian asylums begins
1975	White Paper ***Better Services for the Mentally Ill***
1983	Mental Health Act
1988	The Spokes Report into the Care and Treatment of Sharon Campbell
1991	Residential needs for severely disabled psychiatric patients: The case for hospital hostels
1991	Introduction of the Care Prograrnme Approach for Mentally ill People
1991	***The Health of the Nation*** White Paper
1992	The Reed Review of services for mentally disordered offenders
1993	NHS and Community Act 1990 came into force
1993	Guidance on the discharge of mentally ill people from hospital
1994	Introduction of supervision registers
1995	***Building Bridges:*** A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people
1996	Introduction of supervised discharge
1996	***The Spectrum of Care***
1996	***24 hour nursed care for people with severe an enduring mental illness***
1997	Green Paper ***Developing partnerships in mental health***
1998	White Paper ***The new NHS ~ Modern and Dependable***
1998	White Paper ***Modernising Mental Health Services.***
1999	***Modernising the NHS in London***

so, leaving the "partnership" on this key issue as largely one between the NHS and the voluntary sector.

● The development of Community Mental Health Teams has been slow in most areas and uneven, with some Trusts and health authorities taking many years to change their old-established ways of working. In some areas teams have been established with inadequate resources, resulting in a massive and unworkable caseload on Community Psychiatric Nurses and others. Only in a minority of areas are emergency services from community teams available 24-hours a day.

This patchy and slow development has in many cases been due to cash and resource pressures – with mental health revenue budgets locked into the provision of relatively high-cost care in large psychiatric hospitals, while health authorities and Trusts lack the capital and additional revenue needed to establish community teams.

● This uneven and belated development of community mental health services is one of the main reasons why at least one London Trust, Riverside, has taken issue with the latest government policy guidance, which states baldly that "Care in the Community has failed". [1] At its February 1999 meeting the Board endorsed the view that "The 5 year strategy agreed in 1997 still holds good, in spite of the statements by the Secretary of State that 'Community Care has failed'. ***We believe that it has not yet been given the chance to work*** …" [5]

At least one London Trust, Riverside, has taken issue with the latest government policy guidance, which states baldly that "Care in the Community has failed"

● The grotesque level of inequality in care begins with the extreme social inequalities which prevail across London, and the concentration of mental health problems and needs in the deprived inner-city areas.

● The inequality is compounded by the massive and apparently random variations in allocations of resources to mental health by London's 16 health authorities – which allocate amounts ranging from £38 per head (Bexley & Greenwich) to £149 per head (Kensington, Chelsea & Westminster) and from 7.3 percent to 19.7 percent of health authority spending (1997/98 figures). Another factor is the unfair NHS funding formula for allocating health authority budgets, which seriously underestimates the average level of spending on mental health services across the capital.

● The picture is further confused by equally dramatic variations in policy and in allocation of resources to services by London's 32 boroughs, which are supposed to work in partnership with the NHS, but which also have to comply with their own cash limits and local political pressures.

Local government has always shown an ambivalence about committing serious resources to assist residents with mental health problems, and the impact of central government spending constraints over the last two decades has been further to impede any substantial shift of resources to this minority area of social services.

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● This continuing controversy over the best model for mental health services could also be compounded by a new proposal in ***Modernising Mental Health Services*** which could tip the balance back towards a more hospital-based approach. Health Secretary Frank Dobson's foreword, and the report itself, declare the intention to change the existing mental health legislation, to bring it "up to date".

The changes will include steps "to ensure that patients who might otherwise be a danger to themselves and others are no longer allowed to refuse to comply with the treatment they need" (i.e. impose compulsory treatment). There will also be changes in the law "to permit the detention of a small group of people who have not committed a crime, but whose untreatable psychiatric disorder makes them dangerous." The impact of these proposals on the demand for high-cost secure psychiatric hospital beds, and on the morale of front-line mental health staff who may be required to administer compulsory treatment have yet to be fully assessed.

● The pressure on front-line staff on the wards and in the community has brought a

severe and chronic shortage of qualified staff, which in turn militates against high quality care, and attacks the morale of the staff who remain. Short-staffed services are vulnerable to violent incidents, and leave space for patients to injure themselves or others.

● Instead of regarding the experience, views, wishes and needs of service users as a valuable resource in the monitoring and development of effective and responsive services, too many Trusts and health authorities continue to relegate service users to the sidelines. Too few lessons are sought and learned from the negative experience of many users and their families of the various mental health services in the hospitals and in the community.

Too few lessons are sought and learned from the negative experience of many users and their families

These problems are not new: but neither, unfortunately, are many of the policies which shape the future of mental health care in London and across the country. Frank Dobson's "Third Way", ***Modernising Mental Health Services***, while it has some strong points, and promises £700m extra funding, is if anything less specific and less emphatic on the need to fill the vital gap in care by establishing new units of 24-hour nursed accommodation than was Stephen Dorrell's 1996 ***Spectrum of Care*** document, which contained detailed plans and costings – but offered no extra money. [6]

It now seems that more lobby groups – including a majority of respondents in recent surveys by Mind and the National Schizophrenia Fellowship – are coming round to accept the possibility of amending the Mental Health Act to provide for compulsory treatment in the community as an alternative to compulsory admission. [7,8,9]

However the government proposal – aired in the White Paper and also backed by Home Secretary Jack Straw – to detain of people with untreatable personality disorder is a policy which is more controversial, raising issues of human rights. Such a policy would have a substantial negative impact on existing over-stretched budgets, beds, services and staff.

The London Regional Office is an innovation, and the proposed development of a mental health strategy spanning all 16 health authorities is an ambitious and welcome initiative. But despite a brisk start in launching discussions on a London-wide programme for action, the new Office's ability to monitor, plan and coordinate services across the whole of London is as yet unproven.

Even information systems seem lamentably slow to deliver the promised London-wide facts and figures. A simple question from the author of this report to the London Office, seeking comparative figures on mental health spending across London's 16 health authorities, produced an immediate promise of a reply, followed three weeks later with an apology and a recommendation to ring each health authority separately – since no central information was available. Several of the health authorities in turn found it difficult to answer this one question. Official figures on local authority spending are even more difficult to obtain and appear to be wildly inconsistent and/or inaccurate.

The ignominious failure of the Tory government's ill-fated London Implementation Group stands as a warning of the difficulty of persuading health authorities and Trusts across London to follow any common or concerted policy.

The ignominious failure of the Tory government's ill-fated London Implementation Group stands as a warning

The Regional Office's ***Modernisation Plan*** looks to the London Social Care Region as a means to improve the coordination of social services throughout the 32 London boroughs. However experience over the last two decades or more shows that each council will have to pay attention first and foremost to its own cash limits, its own electorate, and its own existing profile of services.

Health Action Zones promise to draw health authorities, local government and other relevant organisations – including housing – into joint action to address the causes of ill-health, and this could have a specific role in tackling the longer-term care of people with chronic mental illness. But again the amount of new resources injected into the HAZs is limited (£50m between 26 HAZs in England in 1999/00), while health needs in designated Health Action Zones are – by definition – higher than average. It is hard to resist the assumption that the cash limits restraining the participant organisations will remain a

potent force obstructing any real change in mental health care.

There are also grounds for concern that the inequalities in access to mental health services might even be compounded by the establishment of Primary Care Groups from April 1999, which will play an increasingly active role in shaping the commissioning policies of health authorities. The ***Health of Londoners*** report warned that "it is unlikely that an improved service in primary care will do much to reduce the burden on London's mental health services in the next few years."

It went on to warn that: "It seems quite possible that well-intentioned changes led by primary care groups could result in a worsening of an already precarious situation."

The rapid development towards Primary Care Trusts, the first of which could be up and running by April 2000, could also have an impact on mental health services and especially on the functioning of existing Community health service Trusts.

This report will examine a number of these unresolved issues in detail, in an attempt to quantify the scale of the "Care Gap" facing mental health services in London (and potentially other large cities and centres of mental health care).

As the largest organisation representing nursing and other staff in mental health services – in the NHS, in local government and in the voluntary sector – UNISON sees this analysis as helping to set the agenda for change, and laying the basis for the type of alliance between staff, service users, management and government which we believe is necessary if we are to move towards high quality mental health services in the new millennium.

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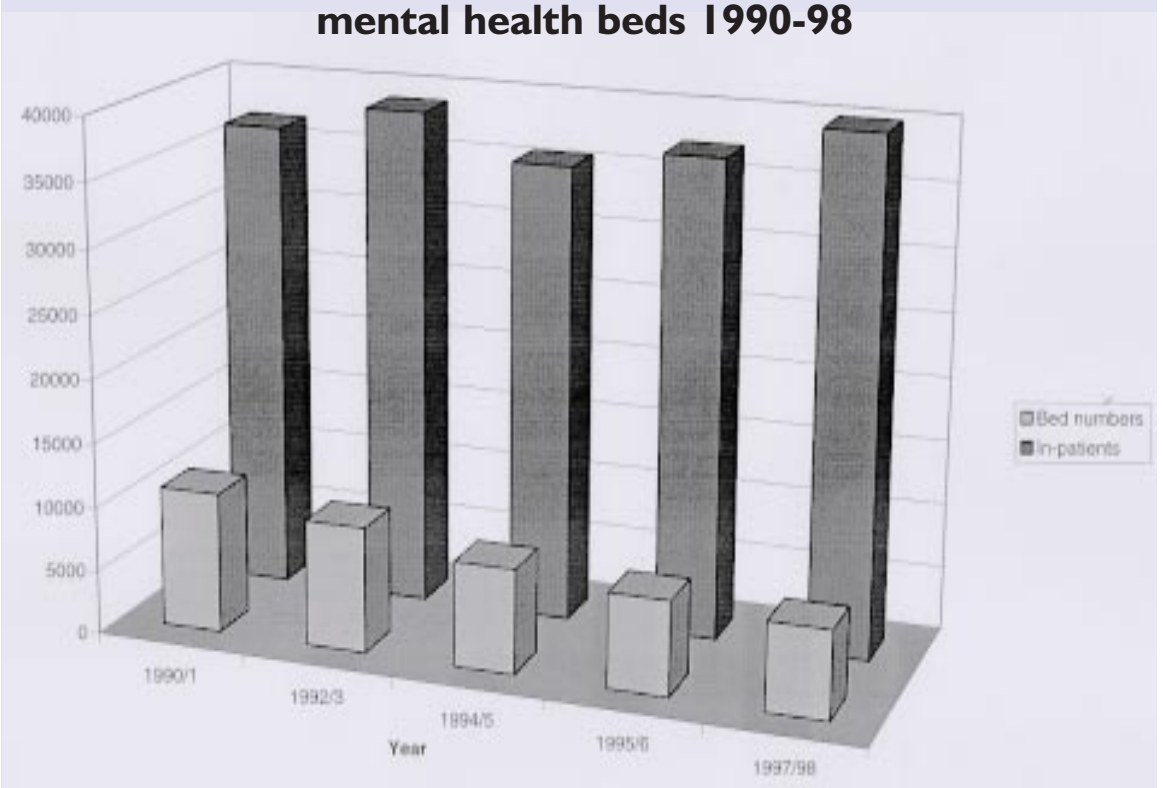
Measuring the Gap

The case of the closed beds

Since 1982 over 10,000 (59 percent) of the psychiatric beds which once served London have disappeared. London's loss of in-patient beds has been larger than elsewhere in England, where an average 56% of mental health beds closed in the last 15 years.[4] But the reduction in hospital capacity has also come against a back-ground of constant or even *rising* numbers of mental health admissions to hospital in the capital, and visibly higher demand for mental health care in London than elsewhere in Britain. Far from abating, the rate of bed closures has slightly accelerat-

Mounting pressure on London's reduced numbers of mental health beds 1990-98



ed in the 1990s. Over 4,000 mental health beds (37%) have closed in London since 1990/91, even while numbers of in-patient episodes have increased over the same period by 9 percent.

With just 14.5% of the English population, Greater London accounted for 17% of mental health in-patient episodes in 1997/98. [10] Even this picture understates the dramatic inequalities between levels of demand in different health authorities in London, and the relative severity of the illness of London patients, who in most areas have to reach a much higher threshold in order to be judged ill enough to be admitted to hospital.[3]

The pressure on the remaining hospital beds has grown year by year: in 1982, London had 17,000 mental health beds to deal with 34,000 admissions. By 1992/93 the bed total had fallen to below 10,000, while admissions had grown in number, to almost 39,000. The latest available figures, for 1997/98, show just under 7,000 beds available, while admissions, though fluctuating in number, have increased again, to almost 40,000. Changes in the pattern of care have therefore led to an increase from an average 2 patients per bed per year 15 years ago to almost 6 patients per bed per year now.

In 1982, London had 17,000 mental health beds to deal with 34,000 admissions. The latest available figures show just under 7,000 beds available, while admissions have increased, to almost 40,000

However there are also inequalities in the pattern of care from one mental health Trust to another. Average numbers of finished episodes of care per bed range from just 2.8 episodes per bed per year in Barnet Healthcare and in BHB Healthcare (covering Barking & Havering) to 9.2 in Camden & Islington and 10.2 in Lewisham & Guy's. The variations reflect different levels of community provision, but also differing numbers of long-stay beds for elderly and adult patients, and whether or not the Trust runs a secure unit.

Opening up a gap

Many of the closed beds were in the ring of 14 large old Victorian asylums on the outskirts of London, which until the mid-1970s contained 90 percent of the mental health beds for the capital. The run-down and closure of these institutions began with the closure of Banstead Hospital in Surrey in 1986, and now includes the closure of Napsbury in Hertfordshire in April 1999. The closures were hailed by many as the first steps towards a more community-based system of care, and as a belated effort to carry through the policy of successive governments since Enoch Powell's famed "Water tower" speech to the MIND conference in 1961, which proposed that the large old-fashioned psychiatric hospitals should be phased out and closed down.

However a succession of reports from the mid 1980s have questioned the extent to which the services provided by the old asylums have been adequately replaced by alternative forms of care in the community.

Early in 1985 the all-party Commons Social Services Committee published a damning critique of the progress on introducing community care, warning that:

"The stage has now been reached where the rhetoric of community care has to be matched by action, and where the public are understandably anxious about the consequences.

"... The pace of removal of hospital facilities has far outrun the provision of services in the community to replace them. It is only now that people are waking up to the legacy of a policy of hospital rundown which began over 20 years ago. Many of the horror stories of mentally ill people living on the streets or miserably in board and lodging are the results of an earlier era.

"... We do not wish to slow down the exodus from mental illness hospitals for its own sake. But we do look to see the same degree of ministerial pressure, and the provision of necessary resources, devoted to the creation of alternative services. Any fool can close a long-stay hospital: it takes more time and trouble to do it properly and compassionately." [11]

A succession of reports from the mid 1980s have questioned the extent to which the services provided by the old asylums have been adequately replaced

The Committee went on to emphasise that extra resources are needed to fund the development of community care: "A decent community-based service for mentally ill people cannot be provided at the same overall cost as present services. (…) Community

care on the cheap would prove worse in many respects than the pattern of services to date."

The Committee also homed in on the overall size of health authority budgets: "Health authorities at present spend scarcely enough per capita on mentally ill patients to enable a decent community service to be provided at the same price, even if immediate and full transfer of patients or cash or both were possible."

The Committee's strictures were echoed and amplified by an Audit Commission report ***Making a Reality of Community Care***, which pointed to the growing gap in services. While 25,000 mental health beds had closed in the preceding 10 years, it warned, only 9,000 new day centre and day hospital places had been created, and numbers of community psychiatric nurses had risen from just 1,300 in 1980 to 2,200 in 1984, implying an overall reduction in care. [12]

The warnings of the mid-1980s were not heeded: the closures continued apace, driven on by government policy and by cash pressures

The warnings of the mid-1980s were not heeded: the closures continued apace, driven on by government policy and by cash pressures on health authorities and Trusts in the capital. Over a decade later, the Tory government itself, and the NHS Executive, were obliged to draw attention to the growing "gap" that had opened up in care for those with long term and severe mental illness.

More recently, a detailed analysis of problems facing services in Waltham Forest in January 1999 identified as a major cause the inadequate provision of in-patient beds following the closure of Claybury Hospital:

"The Health Authority has been aware that, since the closure of Claybury, local services have struggled to contain adult admissions within their existing bed base. As a result emergency patients have been admitted to NHS and private facilities on an ECR basis.… The needs assessment work has confirmed that the number of beds planned in the Claybury reprovision was optimistically low. … In effect 10-15 private sector or distant NHS beds are being used on a permanent basis to make up a local shortfall." [13]

The widening gap in long-term care

While the pressures tend to show up most starkly in the over-occupancy of acute beds, by far the biggest proportional reduction in beds since 1991 has been those providing long term care for adults with chronic mental illness – "adult long-stay" beds. Almost 60 percent of these beds (1,465) have closed in London in the last six years. (By contrast the closure of 1,547 elderly long stay beds represented 55 percent of the 1991 total. Mental health services for the elderly are generally subject to separate planning processes and are not discussed in detail in this study).

In February 1996 the Tory government issued new guidance to health authorities, based on the astonishing — though understated — admission that there was a large and growing area of unmet need. A gap had been created — or at the very least exacerbated — by the rapid closures of beds pushed through by the Tory government itself over the previous 15 years. Thousands of patients across the country (many of them in London) had been left in limbo:

"Mental health planning has by and large been reasonably successful in providing accommodation and rehabilitation for the old, long-stay clients emerging from the old, large institutions.

Changes in mental health bed provision across London 1991-8

Type of bed	Children	Elderly short stay	Elderly long stay	Secure	Adult short stay	Adult long stay	Totals
1991/2 sub-totals	87	822	2805	156	2957	2475	9302
1997/98 sub-totals	120	981	1258	422	3115	1010	6906
Beds gained/lost	33	159	-1547	266	158	-1465	-2396
Change 1991-8 (%)	37.9	19.3	-55.2	170.5	5.3	-59.2	-25.8

However few health authorities have made adequate provision for new long-stay clients with severe and enduring mental illness who may never have been in a large institution, but who will require daily supervision of medication and daily monitoring of their mental state for many years." [6]

Who were these "new long-stay" patients, and how had the system failed them? The NHSE, after the beds had closed, acknowledged that:

"Even in the best of local community rehabilitation services, a small proportion of new patients remain severely ill for long periods of time. There is accumulating evidence, both from research and the reports of recent local experiences, that the needs of this relatively small group of so-called New Long Stay clients are not being adequately catered for.

"They are chronically sick. They need close nursing attention, day and night. They need access to full clinical and day care programmes. At times they may be a serious danger to themselves or others. In the inner cities, many of them come from ethnic minorities. Most will remain ill, dependent, vulnerable and at risk for ten years or more."

"In the old days, they would have languished in the back wards of mental hospitals. Today, ***in the absence of suitable alternative provision***, many can only prudently be provided for in acute hospital beds." [emphasis added, JRL]

"There is accumulating evidence, both from research and the reports of recent local experiences, that the needs of this relatively small group of so-called New Long Stay clients are not being adequately catered for."

Whatever our opinion of the quality of the facilities which used to offer some form of care for these patients, the NHSE clearly admitted in 1996 that important parts of these services had closed in the previous decade. Beds and services had disappeared – despite "the absence of suitable alternative provision", and this was recognised three years ago as a key factor in the massive pressure on the remaining acute beds in London and across the country.

The NHSE guidance went on to underline the size of the gap that had emerged:

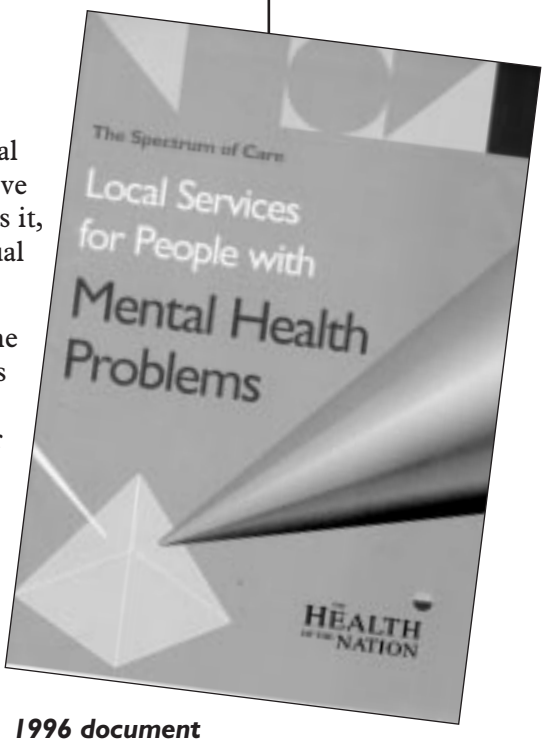
"Recent inquiry reports have demonstrated the lack of such highly-supported accommodation and care for new long-stay patients. Such patients tend either to be inadequately supported in the community or are inappropriately occupying an acute hospital bed." Estimates of the numbers involved suggested around 5,000 people nationally had been cast adrift by these ill-judged changes.

The knock-on effect of the rapid closure of long-stay beds had been substantial:

"Audit shows that up to 40% of people in acute mental illness hospital beds do not need to be there, with the result that they themselves receive sub-optimal care, the bed is not available for another patient who needs it, and their in-patient care has to be provided through an extra-contractual referral."

Most mental health service managers had long been committed to the concept of delivering care in the community, and replacing the services which had mostly been delivered through the large hospitals. But the reprovision of hospital services within the community slid ever further behind the initial target dates drawn up in the early flush of enthusiasm in the middle and late 1980s.

Most of the early schemes were drastically scaled down or abandoned under the combined impact of the slump in property prices, the reductions in NHS capital funding, the draining of regional capital funds by costly acute sector schemes – notably the "white elephant" £230m Chelsea and Westminster Hospital– and the continuing squeeze on the cash allocations to London's supposedly "over-target" health authorities. The problems arising from the desperate lack of pump-priming investment for mental health schemes were compounded by the high price of suitable buildings or sites for



1996 document revealed the gaps in care created by government policies

development of staffed homes in the community, and problems in obtaining planning permission.

In February 1996, Health Secretary Stephen Dorrell responded to the evidence of a care gap by calling on health authorities to set up a network of small-scale units with 24 hour nursing cover, to offer the supervision, medication and support of a long-stay hospital bed, while being situated "in the community". The idea of this type of nursed accommodation was not new: many of the original plans for replacement of the big psychiatric hospitals in the 1980s had aspired to provide this, alongside other, less intensively staffed, accommodation.

The overwhelming obstacle to completing these plans was always financial pressures on health authorities and Trusts. As if oblivious to this problem, the 1996 NHSE guidance, setting target standards for staffing, included projected costings for capital investment and staffing/revenue costs for the new units.

Nevertheless one factor remained unchanged: despite the detailed guidance and costings, neither Mr Dorrell nor the NHSE offered health authorities the additional money that would be needed to begin building any of the new units.

Despite the detailed guidance and costings, Mr Dorrell did not offer health authorities the additional money needed to begin building any of the new units

A chronic shortage

Since that time, further reports have underlined the significance of this gap in mental health services. The 400-page report of the King's Fund Commission, ***London's Mental Health***, returned to exactly this issue early in 1997, when it stressed the problem of "inappropriately placed" new long-term patients in acute wards and the "lack of residential places with 24-hour skilled staffing to which these patients can be discharged." [14]

In April 1997, UNISON's interim report on London's mental health services, ***The Credibility Gap***, used NHSE projections alongside King's Fund definitions of London's 16 health authorities to calculate the likely number of Londoners suffering "severe and chronic mental illness", and likely to require 24-hour nursed accommodation. The total was 3,300, 2,000 of which were in "Inner deprived" London districts, compared with a national estimate of 5,000. [15]

With just over 1,000 adult long-stay beds available in London at that time, it appeared that upwards of 2,000 people with severe and long term problems were either receiving inappropriate treatment in acute wards, or receiving little or no treatment in the community across the capital.

The UNISON report also calculated the cost of supplying an additional 1,500 places in 24-hour nursed accommodation in London, again using Department of Health projections and statistics. It would require 125 new homes, each housing 12 service users, at a capital cost of £70m, and 3,250 staff (including 875 nurses) at an annual cost of at least £60m at 1996 prices – around 10 percent of London's 1996/97 mental health budget.

To supply an additional 1,500 places in 24-hour nursed accommodation in London would cost at least £60m at 1996 prices – around 10 percent of London's mental health budget

Early in 1998, the new government's ***Strategic Review of health services in London*** (the Turnberg Report) made no reference to the outgoing government's policies on mental health, but appeared to draw heavily on the King's Fund analysis. It argued that:

"There is a conspicuous lack of intermediate care which in the case of mental illness includes high support residential placement, supported tenancy and community team intensive support at home. Investment in suitable housing plays a critical part in improving this element of the service. This will require new and recurrent spending but some savings may also be achieved by diverting resources currently spent purchasing long-term private care and accommodation." [16]

Last autumn the chapter on mental health in ***The Health of Londoners*** report also effectively echoed the points made by the King's Fund. It stressed that "A major factor contributing to the inability of service s in the community to stem in-patient pressures is that there are not enough 24-hour staffed residential places to which patients can be

discharged."

The report went on to warn of "the impossibility of providing services adequate for the needs of deprived areas with the resources that are at present available to health authorities."

At the end of last year came the government's White Paper, ***Modernising Mental Health Services***, which declared mental health to be one of four priority areas for government action. It found that across the country there was a tenfold variation in the availability of 24-hour staffed residential beds, and promised that "Additional 24 hour staffed beds will be provided next year over and above those already coming on stream. More will be provided as necessary in later years."

The government's White Paper, *Modernising Mental Health Services*, found that across the country there was a tenfold variation in the availability of 24-hour staffed residential beds

The report also found "serious and disturbing gaps right across the country in the existing range of services available to people with mental health problems". It admitted that:

"Among the other barriers to effective working which were mentioned, finance was identified by three quarters of the Health Authorities surveyed, providing clear evidence that in a wide range of places an insufficient volume of resources was invested in mental health to meet local needs."

The government promised an extra £700m nationally over three years to "provide extra beds of all kinds, better outreach services, better access to new anti-psychotic drugs, 24-hour crisis teams, more and better trained staff, regional commissioning teams for secure services, and development teams."

Acute difficulties

Within all the chaos and variations one common factor which runs throughout the capital is the pressure on the remaining 7,000 in-patient beds, with repeated surveys showing occupancy levels of acute wards averaging well over 100%. However, this is not directly due to closures of acute beds. Indeed, while long-stay beds have been closing, there has been a small ***increase*** in the number of acute ("adult short stay") beds in London.

Numbers have risen 5 percent from 2957 in 1991/2 to 3115 in 1997/98. Acute beds accounted for 27 percent of London's mental health beds eight years ago: now they make up almost 45 percent of the total. The underlying problem is that a varying but substantial proportion of these "short-stay" beds is occupied at any given time by long-stay patients requiring continuing care, but who cannot be discharged because there are inadequate beds or alternative facilities available.

To add to the pressures, many units are experiencing a continued increase in numbers of admissions. Riverside Mental Health Trust, for example, reported on its Hammersmith & Fulham adult services last November that:

Acute beds accounted for 27 percent of London's mental health beds eight years ago: now they make up almost 45 percent of the total

"Average admissions during 1998/9 are up on 1997/8 by 9%.

"Average statutory admissions are up by 13% for the period

"Average gross Occupied bed Nights (OBNs) are 11% higher in 1998/9 than 1997/8."

"Occupancy is 12% higher for this year over last year" [17]

The same summary makes clear that the Trust is only coping with this increased volume of care by speeding up the discharge of patients, with average length of stay cut by 15%, a 33% reduction in delayed discharge and 30% more discharges.

Nor is the pressure restricted to inner London. Barnet Healthcare Trust last summer reported occupancy levels for 1997/98 had averaged 114% for the second year running: Redbridge Healthcare Trust had recorded occupancy levels rising as high as 140%, and averaging between 90% and 116% over the whole year. [18, 13]

Late last year ***The Health of Londoners*** report argued that London's hospitals are almost 800 acute beds short of the level they should have according to the Mental Illnesss Needs Index. It summed up the scale of the deficit in mental health care in the capital:

"Levels of serious mental illness in London are higher than in any other large city in the UK. … Almost twice as many patients in London are detained under the Mental Health Act than elsewhere, and more than twice as many are defined as 'new long stay'." (p105)

"The evidence points to specialist mental health services still being unable to meet demand. They provide only for those with severe mental illness, such as schizophrenia, other psychotic illness and the dementias. There is little support for people with so-called moderate mental illness, such as depression and chronic anxiety" (p108)

"It is difficult to resist the conclusion that some London services have fallen well below a minimal safety level. Urgent remedial action must be taken if further disasters are to be averted." (p110)

Pointing to a shortfall of 780 acute psychiatric beds compared with projected need across the capital (p111), the report's authors went on to argue that "These figures underline the impossibility of providing services adequate for the needs of deprived areas with the resources that are at present available to health authorities". The public health directors are not alone in holding this view: since the Tomlinson Report in 1992, one report after another has argued for an increase in the number of these front-line psychiatric beds.

"These figures underline the impossibility of providing services adequate for the needs of deprived areas with the resources that are at present available to health authorities"

In February 1994 the Tory government set up a Mental Health Task Force to "look at the services provided in London for people with severe mental health problems and to assist local agencies in developing action plans which would address the most pressing problems facing services."

Its report at the end of 1994 was sombre, warning that:

"In the past psychiatric beds have been reduced in a number of districts without a corresponding build-up of effective community services." [19]

A report at almost the same time from the Royal College of Psychiatrists found that seven of the 12 inner London mental health units were discharging patients too early, in breach of government guidelines, but that beds were still running at an average 111% occupancy, with 1,236 patients registered as occupying 1,109 beds. The RCP called for an extra 426 beds in inner London alone to deal with the growing crisis.[20]

On the weekend of November 5, 1994, no acute psychiatric beds were available anywhere in London. Patients were being referred increasingly long distances from the capital for mental health care.

The Task Force followed up its report in April 1995, striking some stark warning notes:

"Almost all Districts report a continuing increase in the pressure on hospital beds ... London DHAs are working hard further to develop services which will reduce the rate of admission to acute psychiatric beds, but in the meantime the Task Force agreed that additional hospital beds were required in a number of Districts." [21]

"Psychiatric beds have been reduced in a number of districts without a corresponding build-up of effective community services."

Among those increases agreed were Ealing Hammersmith & Hounslow (36); East London & City (15); Brent & Harrow (25); Kensington Chelsea & Westminster (20) and Enfield & Haringey (12). It is hard to tell from the published DoH statistics, but it seems that only a few of these promised extra beds actually opened, and that some of these soon closed again.

Certainly by the summer of 1995 when the Royal College of Psychiatrists carried out a survey, things had gone from bad to worse. Average bed occupancy of London's acute psychiatric beds had risen to 122%, in addition to which a massive 96 patients on the

'census day' (July 12) had been sent from over-filled London Trusts to distant psychiatric hospitals – 70 of them to private hospital beds. The RCP found that 48 percent of London's psychiatric in-patients were detained under the Mental Health Act. [22]

A further report in 1995 by the Mental Health Act Commission pointed the finger at the desperate lack of beds, staff and resources as part of the explanation for a grim toll of 39 homicides and 240 suicides by psychiatric patients. The MHAC in particular stressed that bed occupancy levels averaging almost 90% across the country – with inner city levels reaching as high as 130% – could "quite easily" lead to staff inappropriately giving leave to some patients. [23]

There was no let-up in the pressure on front-line services. In the autumn of 1997, the Chief Executive of Lewisham & Guy's Mental Health Trust reported that bed occupancy levels on John Dickson Ward (Guy's) had reached a staggering 230 percent in September. One board member "expressed concern that the occupancy rate had reached that level", and was assured that "measures had been introduced to reduce the pressure on beds". [24]

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That same autumn saw bed occupancy running at 150% in Enfield, to the alarm of the Mental Health Act Commission. These levels of occupancy inevitably reduce the quality of care for patients: in October 1997, Riverside Mental Health Trust discussed a Locality Plan for South Kensington and Chelsea which pointed out that:

"It should be noted that there are 33.5 wte nurses on Mulberry Ward, staffing 41 beds with an average occupancy of 110%. It is therefore not possible for nurses on Mulberry Ward to provide 24-hour therapeutic input to patients." [25]

The pressures have continued at a high level. Riverside MH Trust reported in February that its bed occupancy levels for 1998/99 would be 104 percent for South Kensington & Chelsea and 109 percent for Charing Cross. Private sector Occupied Bed Nights had been reduced – but were still running at 488 for February 1999, costing upwards of £120,000 for that month alone, equivalent to around £1.5m a year. [26]

In Hampstead, the Mental Health Act Commission visit to the Royal Free Hospital in September 1998 found that "Pressure on beds continues, resulting from inadequate aftercare community residential provision for patients with both "health" and "social" care needs, difficulties in funding and delays in Health Authority assessment procedures. This is compounded by the 50% reduction in intensive care places, following the transfer of services from Napsbury to Edgware General. This has led to an increase in the use of Extra Contractual Referrals and continued use of "leave" beds to accommodate new acute referrals." [27]

In January 1999, Linda Smith, chair of Lambeth, Southwark & Lewisham health authority reported on a visit to Lewisham's Ladywell Unit, where occupancy levels were running at 148 percent. This confirmed the warnings of the Lewisham & Guy's Trust last autumn that LSL projections for acute admissions were drastically wrong – indeed as low as half of the actual level of demand. "In central and East Lewisham the predicted number of admissions for the year was 200, which contrasted with 196 admissions over the last six months." [28]

Secure beds

Out of 24,000 mental health patients formally detained to NHS hospitals (including high security hospitals) in England in 1997/98, 44% (10,500) came from the London area. Rates of detention for London's population, at 148 per 100,000, were 70 percent higher than the English average of 87 per 100,000, and more than double the lowest rate (67 in Eastern Region). This level of compulsory admission and treatment puts a tremendous strain on facilities, staff and mental health budgets in the capital. [29]

Rates of detention for London's population, at 148 per 100,000, were 70 percent higher than the English average of 87 per 100,000, and more than double the lowest rate

In 1992 the Reed Report on services for mentally disordered offenders (MDOs) called, among other things, for an increase to 1,500 in the number of secure beds available

nationally, to ensure that those with psychiatric problems were treated in hospital rather than imprisoned.

Progress on this has been extremely slow, in part hampered by lack of cash. In February 1996 the NHS Executive's ***Review of the Purchasing of Mental Health Services*** promised just 1,200 purpose built medium secure beds would be available for England "by March 1997". [30]

Several London health authorities have drawn attention to the dramatic increase in numbers of MDOs being cared for by the NHS since the Reed Report, with rising pressure on local Trusts and ever-more patients referred to more distant secure units, sometimes in private hospitals – at considerably increased cost.

Spending on MDOs by Lambeth, Southwark & Lewisham (LSL) has rocketed five-fold, from £4m a year (fewer than 40 patients) in 1992 to a projected £20.5m in 1999/00 – more than 20 percent of the local mental health budget. In outer London, too, the problem has been growing: Enfield & Haringey HA report spending on medium secure care almost doubled in three years, to £4m in 1997/98. [31,32]

Spending on MDOs by Lambeth, Southwark & Lewisham has rocketed , from £4m a year in 1992 to a projected £20.5m this year – more than 20 percent of the local mental health budget.

While this massive increase in pressure on mental health budgets has been widely recorded and commented upon, it has not been met by full funding from the government. LSL complains that despite a 14 percent increase in activity in caring for MDOs in 1998/99 "the level of our mentally disordered specific grant has remained at the same level since it was negotiated two years ago".

Similar problems affect East London & City HA, where real terms resources for mental health services "are likely to remain unchanged over the next five years", but where "the number of mentally disordered offenders is projected to rise. The cost of this rise in numbers is to be contained by the development of Forensic hostels and Forensic CPN teams … pump-primed by MDO special assistance funding for the three year period ending March 2000." [33]

Department of Health figures show a near-threefold increase in the allocation of "secure" NHS psychiatric beds in Trusts across the capital since 1992 (from 154 to 432), compared to a modest rise in numbers of adult "short stay" beds and a drastic reduction in long stay beds. Acute and secure beds now comprise more than half of London's complement of psychiatric beds.

The Health of Londoners report points out that London as a result now has "more than four times the number of medium secure places" than other deprived UK inner cities (11.5 per 100,000 population in inner London, compared with 2.9 per 100,000 in other deprived UK inner cities). "The creation of the Strategic Assistance Fund to address the rising demand from mentally disordered offenders is welcome, but its continuity is not guaranteed." (p105)

Department of Health figures show a near-threefold increase in the allocation of "secure" NHS psychiatric beds in Trusts across the capital since 1992 (from 154 to 432)

However the new NHS secure units rely on extremely high occupancy levels for their financial viability – putting tremendous pressure on staff. In September 1997, East London & City Health Authority (ELCHA) examined the Outline Business Case for an extended medium secure unit, during which it was stressed that:

"Affordability depends crucially upon the ability of the Crozier Terrace unit … to deliver a lower length of stay than the out of district providers used currently by ELCHA, and to maintain high occupancy levels. The targets of 8 months stay and 97% occupancy are therefore important deliverables." [34]

Extra Contractual Referrals (Out of Area Treatment)

With front-line services in London's mental health Trusts under desperate pressure, a major consequence has been the wholesale export of patients as "extra contractual referrals" (ECRs) to the (few) NHS providers with spare capacity outside the capital, or to the private sector, also in may cases miles from London. The subsequent reorganisation of the NHS has meant that these referrals

are now termed "Out of Area Treatment" episodes (OATs).

Trusts have been conspicuously reluctant to spell out the full scale of this problem, and few Health Authorities in London have responded to UNISON's repeated recent questionnaires seeking details for use in this report. This makes it impossible to do much more than guess at the total amount of money flowing out of London's NHS each year, or the scale of the problems posed for health workers and social services in attempting to arrange and follow up the discharge of such patients back into the community they came from. No social services department appears to have drawn attention to the costs of its involvement in these type of long-distance discharges.

Kensington Chelsea & Westminster HA spent £6.8m on ECRs in 1997/98, two thirds of it in the private sector.

However the recent study on services in Redbridge & Waltham Forest sets out a number of reasons why this type of service represents poor value for the NHS (all of which coincide with the points raised by UNISON two years ago):

* It is very expensive, with the bed charge 2-3 times the cost of a local bed

* Poor liaison with local community services increases the time people spend in hospital, providing a poor service at higher cost

* Distant placements, for example in Ealing, puts strain on families and friends who try to maintain contact

* Severe operational problems in making emergency admissions result, particularly for Social Services

* Inappropriate local facilities are being used for adult inpatients …

* There is no investment in local services.

* As a result of these pressures, the [RWFHA] Health Authority is currently projecting an ECR spend of over £2m, against a budget of £1.15m, to pay for services of questionable quality." [13]

The problems are widespread throughout the capital. Croydon Health Authority was warned last September that spending on mental health ECRs was set to overshoot by 64% (£900,000 on a budget of £1.5m). [35]

In inner London, as with every aspect of mental health services, the pressures are greater. Kensington Chelsea & Westminster HA spent £6.8m on ECRs in 1997/98 (two thirds of it in the private sector), and attempted to reduce this to £5m by a variety of changes in services in 1998/99. [36]

However the attempt to squeeze a quart of demand into the NHS pint pot of beds is having an impact on the level and quality of care. At the end of 1998 the Lewisham & Guys Trust Board was told that "as there were difficulties finding private placement beds the Trust might need to raise the admission criteria threshold". "The other Trusts involved in the proposed [SE London] merger were facing the same problems." [37]

Private concerns

In 1982 5% of mental health beds nationally were in the private sector. By 1994 that figure had risen to an astonishing 43%

The squeeze on front-line NHS acute mental health beds has led to a runaway growth in spending on beds in private sector hospitals – often many miles outside London. In 1982 5% of mental health beds nationally were in the private sector. By 1994 that figure had risen to an astonishing 43%. The scale of the current problem is difficult to measure, because the last Conservative government ceased collecting national figures.

The problem is sharpest in London, with some districts under massive pressure. Lambeth Southwark & Lewisham HA reports (March 1999) that around 20 percent of all mental health admissions in the district now "over-spill" into private sector beds. [38]

Most inner London mental health Trusts would admit to using an average of 15 - 30 private beds a day. The daily cost for 'extra contractual referrals' to a private hospital is

between £250 and £350 per day. Many charge additional costs of £150 or more for admitting patients and for such 'extras' as special nursing, doctors' fees and the other necessities of a hospital stay.

Inner London Trusts, therefore, each pay out an average of £500,000 or more per month. Few outer London Trusts can see a lot of change from £1m annually, which could have been used to pay for a couple of medium sized ward teams or provide a massive boost to community services. The London total is likely to be in the region of £50m a year consumed by what we have seen is often poor quality care at long distance from the communities involved.

The London total is likely to be in the region of £50m a year consumed by what we have seen is often poor quality care, at long distance from the communities involved.

Nationally, there must be further tens of millions of pounds leaking annually straight out of the NHS into the private sector in fees for beds and agency nurses. The lack of investment in a decent public service only increases its reliance on the private sector as NHS staff struggle with the inherent inefficiencies they face. Inevitably, it is the front line clinicians who get the blame for being unable to "cope" or manage the problem.

As long as this situation continues there are therefore major questions to be answered not only about the cost effectiveness of such arrangements but also about New Labour's commitment to a public service, to those who work in it and to those who use it.

In September 1997 the Outline Business Case for an expanded NHS secure unit in Hackney gave an insight into the costs of purchasing additional secure unit placements from the private sector – often using hospitals many miles outside London. 31 out of 66 ELCHA patients in MSUs were in private sector beds, of which the main provider, Kneesworth House, had a unit price of £267 per bed day in 1997. By this reckoning, each bed at Kneesworth was costing the NHS £1,869 per week, with the bill for ELCHA's 31 patients running at £3m per year. [34]

Lewisham & Guy's Trust estimated that "an average of four people were placed in non-Trust facilities in September 1998. … These placements cost approximately £8,000 per month." [39]

But it is not a simple matter to reduce this dependence on private beds. Riverside Trust in their November meeting heard their Chief Executive warn of the possible consequences of trying to squeeze down the use of private sector beds: "This did however have consequences for the wards, as their levels of morbidity and violence increased." [40]

The scale of the financial commitment of purchasing private beds on this scale to keep London's mental health services afloat is a scandal. If capital and pump-priming revenue were available to build suitable alternative NHS facilities in London – especially the much-vaunted "24-hour nursed accommodation" to relieve the acute wards of the pressure of long-stay patients – this waste of public money could be drastically reduced or ended, alongside an improvement in the quality of care. In the longer-term much or all of the additional revenue costs could be recouped for the NHS.

No real progress in developing a more appropriate infrastructure for London's mental health services is likely to be made unless there is a government commitment to fund the fresh investment that is required, with an extraordinary injection of additional cash.

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Community affairs

In February 1994, the report of the official inquiry into the care and treatment of Christopher Clunis unmasked the chaotic patchwork of fragmented services and buck-passing between parallel cash-limited and under-resourced departments and authorities which had emerged in place of the "seamless service" promised in the last round of community care reforms.

It was announced that supervision registers would be introduced for mentally ill people from April 1. Once again, a policy was pronounced by ministers but no extra money was to be made available to fund this increased workload.

In May 1994, toughened guidelines were issued on the discharge of mental patients. These placed "particular emphasis on the need for risk assessment prior to discharge" and stressed that patients should be "discharged only when and if they are ready to leave hospital ... so that any risk to the public or to the patients themselves is minimal and is managed effectively." Once again this raised, but did not answer the question of ensuring that there are adequate numbers of suitable beds and places in supported accommodation available to offer professionals a real choice in making such assessments.

The autumn of 1995 revealed even more glaring gaps in the service and the failure to implement recent government policies. Figures published by the North Thames Regional Health Authority showed that less than ten percent of the patients put on "supervision registers" had been seen even once a month between April and June. [41]

The figures also revealed the wide disparity in numbers of patients put on supervision registers under the 'Care Programme Approach', which was supposed to have been in force since 1991. Nine health authorities in North Thames had put no patients at all on the register, suggesting that perhaps for them the guiding principle was not the letter of government policy, but the lack of resources to follow up and deliver genuine supervision in the community.

Social roots of inequality

London is Europe's biggest city, and the sheer scale and diversity of its population pose problems for the provision of adequate access to mental health services. Among the city's 7.1m population are half of Britain's known drug abusers, 60 percent of the British homeless population, and 109,000 single homeless people.

Mental health problems are strongly linked with social deprivation, and it is estimated that up to 24 percent of London's population was living in poverty in 1992.[3] 40 percent of London's population live in electoral wards which are among the most deprived 10 percent in Britain.

Levels of unemployment across Greater London as a whole are higher than the English average, with many inner London boroughs suffering some of the worst unemployment rates in the country. 43 percent of Greater London's 260,000 unemployed in July 1996 had been out of work for more than a year. Unemployment also falls especially hard upon ethnic minority population, with a massive 40 percent of non-white 16-24 year olds out of work in 1995 compared with 17 percent among white groups. (ibid)

According to the 1992 Tomlinson Report, "inner London presents a range of health need unparalleled in the rest of England". [42] The same report estimated that there were 120,000 refugees living in the inner-London districts of North Thames alone: this total has almost certainly increased, and a majority of refugees live in London. Many of these do not speak English, but will have special health needs, including mental health problems stemming from the traumas they have suffered in their native countries and compounded by negative experiences of racism and exclusion in the UK.

Almost half of all the UK's ethnic minority population live in London – including 77 percent of the Black Africans and 58 percent of Black Caribbeans – accounting in all for around 20% of the capital's population. About half of London's ethnic minority population were born in the UK. [43]

The Health of Londoners report, uniquely, and without citing any sources, argues that despite accounting for only one in five of London's population, people from ethnic minorities account for almost half of the capital's mental health admissions to hospital. Although detailed local figures are not universally available and patterns vary, all the statistics point to an over-representation of people from ethnic minorities in London's psychiatric beds. Most of the over-representation of the non-white population is among young men of Afro-Caribbean origin.

Other factors known to increase the risk of mental illness are also found in concentrated

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form in London, including above-average proportion of 15-30 year olds, double the English average proportion of single person dwellings, and high rates of social exclusion such as being single, widowed or divorced.

A service under pressure

Under these pressures, London has higher levels of serious mental illness than any other large city in Britain. Rates of admission to psychiatric hospital rose by 26 percent in London between 1989 and 1994, compared with a national rise of 18 percent. London has 14.5 percent of the English population, but its 40,000 mental health admissions represented 17 percent of the English total in 1997/98.

Almost twice as many patients in London stay in hospital for more than 18 months compared with elsewhere. 37 percent of London in-patients are diagnosed with schizophrenic illness compared with 26 percent in the rest of Britain.

Inner deprived areas of London have levels of psychiatric admission 33 percent higher than inner deprived areas of other big UK cities, and higher bed occupancy. Four times as many patients are in medium secure places, and inner London's health authorities spend more than a third more of their total health budget on mental health. [14]

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However the allocation of health authority resources to mental health varies widely from district to district across the capital. The UNISON survey in 1997 showed that health authorities spent widely varying amounts of their total budget on mental health services, ranging from 9.4 percent (Bexley & Greenwich) to 21.2 percent (Lambeth, Southwark & Lewisham). The latest complete figures available, for 1997/98, show that these immense variations continue.

The London average share of spending on mental health is 15.8 percent, equivalent to around £600m in 1997/98. By contrast the national NHS funding formula is based on an assumption that 10.8% of health budgets will be allocated to mental health. [44] Had London's health authorities adhered to this norm, spending would have been £200m lower.

Actual NHS spending on mental health per head of local population also varies widely – from a low of £38 to a high of £149. This contrast may appear to be one between inner and outer London. However there are substantial variations even between apparently similar health districts: three of the outer London HAs spend between £38 and £50 per head of population, while Barnet and Barking & Havering each spent more than £55 and

London's varying mental health budgets 1997/98

Health authority	Mental health spend as % of HA budget	Mental health budget (£m)	Population	Mental health spend per head (£)
Barking & Havering	12.7	23.0	385,789	59.6
Barnet	12.0	17.9	312,431	57.3
Bexley & Greenwich	7.3	16.4	431,653	38.0
Brent & Harrow	16.8	38.7	455,401	85.0
Bromley	12.0	17.1	293,385	58.3
Camden & Islington	16.8	52.7	358,402	147.0
Croydon	11.0	16.5	330,933	49.9
Ealing Hammersmith Hounslow	14.6	50.4	652,162	77.3
East London & City	16.0	55.7	600,575	92.7
Enfield & Haringey	16.8	39.8	474,879	83.8
Hillingdon	11.4	11.1	245,295	45.3
Kensington Chelsea & Westminster	17.3	52.3	349,165	149.8
Kingston & Richmond	15.8	19.5	315,716	61.8
Lambeth, Southwark & Lewisham	19.7	99.0	733,397	135.0
Merton, Sutton & Wandsworth	12.5	52.0	610,657	85.2
Redbridge & Waltham Forest	15.0	35.2	448,411	78.5
London	**15.8**	**597.3**	**6,998,251**	**54.1**

Figures compiled May 1999 by LHE from HA and London Regional Office data

Kingston & Richmond and Redbridge & Waltham Forest spent £62 and £78 respectively, a variation of almost 100 percent between the top and bottom spenders among the outer boroughs.

Within inner London, too, there are variations, though less dramatic, between the East London & City allocation of £92.70 per head and the KCW figure of £149 – a gap of over 60 percent.

The variation in the share of council spending allocated to mental health services is enormous, with a low of 3.5 percent of PSS budget to a high of 11.9 percent in 1997

Inequalities in social services

The situation is equally confused when we consider the variations in council spending on services for people with mental health problems. As might be expected, given the social pressures, London boroughs account for 17 of the country's top 20 councils in overall spending on Personal Social Services for the adult (18-64) population. 25 London Boroughs also spent above the English average amount per head on mental health, with 16 of the 20 top-spending councils in 1998. Inner London Boroughs spent between double and five times the English average.[45]

However the variation in the share of council spending allocated to mental health services is again enormous across London and between different Boroughs in inner and outer London, with a low of 3.5 percent of PSS budget to a high of 11.9 percent in 1997.

Actual spending also varies, with the top-most Borough spending seven times as much per head as the lowest spender. Outer London Boroughs vary between Redbridge at the bottom, spending just £10.56 per head of adult population in 1998, to its neighbouring Borough Waltham Forest at the top, spending £40.43 – nearly a four-fold difference. Inner London spending ranges more than two-fold, from just £31.36 in Lewisham to £81.35 per head in Camden.

Nor is there any consistency in the direction of council policies on mental health. Any attempt by the London Social Care Region to even out these disparities and move towards a more coherent and consistent provision of services seems beset with problems. One of these problems is the difficulty of obtaining accurate and conssistent facts and figures. There appear to be great disparities an inadequacies in the recording of detailed information on local service provision and budgets, with Department of Health figures often running directly counter to the actual changes on the ground.

The latest figures show six Boroughs (three inner London, three outer) planning to ***cut*** spending per head by as much as 25 percent in 1999, while the others are proposing ***increases,*** ranging from 1-107 percent. How much of this variation is due to inadequate information rather than policy changes is hard to determine without individually ringing each Borough.

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Partly reflecting different division of labour with the various health authorities, partly reflecting historic patterns, and partly the result of debates over resources and political priorities, the services provided by local Boroughs also vary as widely as the spending allocations. While Lambeth offered less than 10 weekly mental health day centre places for every 10,000 adult residents, for example, Islington provided 75 and Haringey almost 120 in 1998 – a 12-fold variation.

Spending on day centres appears to have been been cut since 1991 in three Boroughs – at least one of which we know has actually increased spending. But over the same period spending on the same type of service appears to have gone ***up*** in 21 Boroughs, with increases ranging from 8 percent in Havering to 113 percent in Harrow and 205 percent in Merton.

Use of the available day centres also varies, from an average of less than one weekly attendance from every 10,000 adult residents in Havering, and 2.4 in Lambeth, to 41 in Kensington & Chelsea.

Council spending on residential care for mentally ill people spans a tenfold difference between a low of £1.74 per head of adult population in Bromley to a high of £18.39 per

head in Tower Hamlets, with two thirds of London Boroughs spending above the English average of £3.68.

A third of London's Boroughs provided less than the English average level of support for long-stay residents with mental illness: the variation was between Havering, supporting an average of 0.7 per 10,000 adults, to Bromley, supporting 23 – a thirty-fold difference between services in two outer London Boroughs with comparatively low levels of deprivation.

26 of London's 32 Boroughs provide less than the English average of nursing care for people with mental illness – effectively abdicating responsibility to the NHS: 13 Boroughs provided none at all in 1996.

Social services budgets, like those of Health Authorities, have also suffered from financial cutbacks over the last few years. Some of these can have a serious impact on mental health services.

In November 1998 Riverside Mental Health Trust pointed to problems because: "Pressure on social services care management budgets in Hammersmith and Fulham are leading to significant levels of delayed discharge which is impacting on the Trust's ability to manage the acute risk share agreement." [17]

In north London, Islington council last December put forward plans to close a mental health day centre serving 150 clients and further restrict access to care from community services as it struggled to cut £5.6m from its £71m social services budget. [46]

Plans for the development of a new mental health strategy for Croydon, combining resources from the health authority and council have been hit by the impending cut of £4.5m in Croydon's social service budget in order to bring it into line with government spending limits (SSAs). [47]

With no overall guiding policy, no uniformity of resources, and no guarantee of matching resources from health authorities, it is scarcely surprising that councils' mental health services across the capital appear more like a (rather moth-eaten) patchwork quilt than a seamless service.

We have yet to see any evidence that these inherent problems can be confronted, tackled or resolved through the mechanism of the London Regional Office, which may have the ear of health ministers but lacks any democratic mandate to influence policy in the 32 Boroughs.

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New policies: a way forward?

Investing in mental health: assertive outreach

In May 1997, Kensington Chelsea & Westminster Health Authority (KCW), one of the few London HAs to receive substantial additional funding under the current financial allocation formula, agreed a new Mental Health Investment Plan. The Plan set out to "fill gaps" in local services, and reduce spending on private sector ECR beds (then running at £6m a year in KCW). [48]

The priorities were: "To improve the availability of secure services, continue to reduce ECRs, continue developing user-led monitoring of services and to start to improve the availability of accommodation". An additional £1.1m was added to the contract with West London Healthcare, to fund the running of an additional three medium secure beds, two low secure beds and five low secure long term rehabilitation beds.

The key change in terms of community based services was the development of an "assertive outreach" service in South Kensington & Chelsea, along with an extension of the emergency assessment services and the establishment of a crisis care service (though only for 12, not 24-hours a day).

The London Regional Office may have the ear of health ministers, but it lacks any democratic mandate to influence policy in the 32 Boroughs.

The complete community team structure, which was expected to take five years to establish, was projected to cost an additional £800,000 a year, with considerable requirement for additional senior qualified nursing and therapy staff. The plan drawn up by Riverside Mental Health Trust was most unusual in containing a detailed breakdown of staffing requirements and running costs for the proposed community schemes.

The plan was a response to perceived gaps in the service which meant that – according to Trust projections – an estimated "52 percent of admissions investigated could have been prevented had alternatives been available." [49]

It also began to address the thorny problem of the lack of suitable supported housing for patients awaiting discharge from psychiatric beds, warning that:

"Due to high property prices and restricted development opportunities, both supported accommodation and mainstream social housing are in short supply in the locality, resulting in long waits to be placed or rehoused. Not surprisingly, a lack of suitable accommodation is the main cause of delayed discharge from hospital. Particularly where high care placements are required, there is usually a need to look outside the locality and/or the Borough."

KCW HA is now carrying out a detailed analysis of the local provision of supported accommodation, working with the Royal Borough of Kensington & Chelsea. [48]

The new Plan aimed to reach a core group of clients who have had a high number of readmissions by establishing team-based assertive outreach, in which each CPN attached to the team would have "a caseload of no more than 15 clients".

The first full year of the scheme appears to show uneven progress towards the ambitious targets, as the first part of the new system has been assembled. Monitoring figures do show that the additional investment, together with the full cooperation and additional efforts by staff, have managed to contain the numbers of private sector ECRs. However this does undoubtedly place greater strain on the NHS wards, where staff are struggling to cope with what Chief Executive Ann Windiate described as "increased levels of morbidity and violence". [40]

During the summer of 1998 high levels of activity in South Westminster brought an increased use of private beds: the costs of this resulted in KCW halting further investment in the locality plan. Yet without the proper provision of community-based services the scope to cut hospital admissions cannot be fully tested.

Overall, the new profile service has yet to prove itself able to deliver the promised changes. Since April there are also grounds for concern at the continuity of the investment plan, since Riverside Trust has been dismembered, with part being merged with the former NW London Trust to form a new Brent Kensington Chelsea & Westminster Trust, and the other part merging with West London.

In the process, most members of the Riverside Board have failed to find posts. Significantly one of the final acts of the outgoing Riverside Board was to re-publish its 1997 Plan, arguing that community care – as epitomised by those proposals – has not yet been given a chance to work.

Elsewhere, established assertive outreach services are regarded as playing a useful role in reducing admissions to hospital. [50] In Waltham Forest, two such teams, working with CMHTs, are in contact with 65 individuals who might otherwise be at risk of repeated readmissions: but they "do not have the capacity to take on more clients". [13]

A widening base of experience elsewhere suggests that investment in improved community services including assertive outreach may – especially if linked to the provision of sufficient suitable accommodation outside the hospital setting – achieve the objective of stabilising or reducing the number of admissions. [51]

However this requires health authorities which have not so far recognised this need to

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pump substantial extra revenue and capital investment into the establishment of new outreach teams. The Riverside plan shows that if this is properly resourced by sufficiently qualified staff it could cost up to £1m per year per authority, in addition to the extra accommodation and beds that will be needed.

The London Regional Office has correctly decided to prioritise projects for establishing assertive outreach for a chunk of its additional £6m investment in 1999/2000: but more will be needed to ensure adequate services are available throughout the capital.

24-hour nursed accommodation

For almost a decade the formal government policy for filling the gap in care created by the closure of adult long-stay beds has been to urge greater provision of 24-hour nursed accommodation for patients with enduring and severe mental illness. As we have seen, no serious additional funding has yet been made available to enable Trusts, Health Authorities or local authorities to procure this additional accommodation.

But the situation is even more complicated, because it is clear that a number of health authorities and local councils disagree with the policy of providing more: some indeed are looking to restrict or reduce the level of nursed accommodation they provide.

A recent report on Redbridge & Waltham Forest Health Authority found that in outer London as a whole "there was over-provision of 24-hour nurse staffed accommodation". However a shortfall of these beds in Waltham Forest was accompanied by higher than expected spending by the Borough on community services and day centres , as part of a conscious policy to restrict its provision of residential care. [13]

In west London, Ealing Hammersmith and Hounslow Health Authority (EHH) in its annual review of mental health services pointed out that the West London Healthcare Trust was "focusing on prevention of admission to hospital through assertive outreach and crisis interventions rather than planning new 24-hour nursed accommodation. … Hounslow & Spelthorne Community & Mental Health Trust is also focusing on initiatives designed to maintain vulnerable clients in the community." (July 1998) By contrast the Riverside Trust provided two 24-hour nursed services, an intensively staffed house (13 beds) and The Haven, in Epsom, with 67 places. [52]

In Croydon, the 1999 report of the Mental Health Joint Planning Team questions the wisdom of spending 40% of the Social Services mental health budget on funding 200 places in 24-hour staffed accommodation. [47]

By contrast Hillingdon HA's Strategic and Financial Framework has set aside £300,000 in NHS growth money to plan for new units of 24-hour nursed accommodation (March 1999). [53]

There can be problems finding suitable premises and obtaining planning permission for the establishment of the government model of 24-hour nursed accommodation. Barnet Health Authority reported in September 1998 that it had still not been possible to establish such a unit in advance of the closure of Napsbury Hospital, forcing Barnet Healthcare Trust to adopt temporary measures to house nine patients. [54]

Compulsory treatment

While it appears that opinion among mental health pressure groups has become more receptive to the idea of compulsory treatment in the community as a preferable option to compulsory admission to hospital under section, there will be real problems if this policy is to be implemented in London.

It is clear that a number of health authorities and local councils disagree with the policy: some indeed are looking to restrict or reduce the level of 24-hour nursed accommodation they provide.

London Regional Office allocations

With £6m to allocate for 1999/2000, the London Regional Office has given a total of £1.1m each to LSL and Camden & Islington; £825,000 each to ELCHA and Enfield & Haringey, to fund a combination of 24-hour nursed beds and assetive outreach teams, and £375,000 each to Barnet and Brent & Harrow for assertive outreach.

Mind has continued to express its reservations on the civil liberties aspect of the policy: but there are also considerable implications for health authorities and health workers. To implement this new regime would require a substantial increase in staffing for many of the existing Community Mental Health Teams – and the establishment of new teams where none presently exist.

This will obviously require more money: but it will also fundamentally change the character of the work carried out by many Community Psychiatric Nurses, numbers of whom have opted to work in the community rather than in institutional settings in order to be able to develop relationships of greater trust and respect with their clients.

If CMHTs become identified in the minds of increasing numbers of the public with the enforcement of drug regimes and the imposition of treatment, much of this respect and trust is potentially at risk. The recruitment of these staff could become more difficult. A short-staffed team involved in the administration of compulsory treatment could find its members involved in hazardous situations, jeopardising the safety of clients and staff alike.

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There needs to be a full analysis of the financial, social and morale costs of this change in service before any final decision is taken, in which the views of service users and front-line staff must be taken seriously into account.

We should remember that compulsory treatment is no panacea to solve the problem of the small minority of "high risk" mentally ill people who become violent towards themselves or others. The recent Confidential Inquiry concluded that even if it secured 100% compliance with medication, compulsory treatment would prevent only two killings a year. [55]

Personality disorder

There are even bigger potential pitfalls and even less of a consensus over the compulsory detention of people diagnosed as having "severe personality disorder", whether or not they have committed any crime. Home Secretary Jack Straw has urged that several hundred such people should be detained for an "indeterminate but reviewable" sentence: but since they have not been convicted, they would presumably become the responsibility of the overloaded mental health services rather than the overloaded prison system.

Human rights organisation Liberty has pointed out that "Proving that you are not dangerous is almost impossible, and there is no doubt that people who are not dangerous will be locked up." But for mental health workers there are also serious issues involved in enforcing the compulsory detention of a "patient" who by definition is deemed to have a condition which cannot be treated. The possibility of becoming little more than prison warders could act as a further deterrent to the recruitment of nursing staff.

Nor has there been any sober assessment of the financial burden this would put on existing mental health services. Perhaps the government intends to create a new Special Hospital along the lines of Ashworth or Broadmoor. Since many of the individuals to be confined under these proposals would come from London, the details are important.

Primary Care Groups

The latest government reforms, introducing Primary Care Groups, continues to promote the notion of a "primary care-led NHS" which became popular with ministers and NHS planners in the early 1990s. ***Modernising Mental Health Services*** claims (without offering any supporting evidence) that "Primary Care Groups will be in a strong position to promote mental health and to develop strategies for those who are at risk".

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However the ***New NHS*** White Paper singled out mental health as one area of care which should not be incorporated into Primary Care Trusts, but continue to be provided by specialist mental health care Trusts. Last autumn's ***Health of Londoners*** report

endorsed this view.

Kensington Chelsea & Westminster Health Authority has also sounded a warning note against the commissioning of mental health services being transferred to Primary Care Groups, arguing in January that:

"Unlike most services, GPs are not the significant gatekeeper to secondary mental health services. Self referrals, referrals from social services and other agencies including the police are more common than referrals from GPs.

"We are in the middle of a complex development programme which needs continuity and a KCW-wide perspective.

"GPs themselves recognise the complexity of mental health services". [56]

Organisations representing service users, too, have expressed concern at the possible implications of a "primary care-led mental health strategy". Southwark Community Health Council, responding in April 1999 to the Lambeth, Southwark and Lewisham Health Improvement Plan (HImP) warn that, among other problems:

"There are insufficient resources committed to improving primary care mental health services.

"Important topics have been missed from both GPs and nurse training, on the particular needs of local people." [57]

There is little or no evidence that London GPs are ready or willing to undertake additional responsibility for mental health. Far from GPs taking over the care of patients from mental health Trusts, one impact of the extension of fundholding to GP practises in outer London, according to the King's Fund Commission was "less severely mentally ill patients being referred to community mental health teams".

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The general picture of unplanned and uneven mental health services between London's health authorities – and even of equally large differences within health authorities – also appears to apply at the level of primary care. According to the 1997 King's Fund report ***London's Mental Health***, counselling services were completely unavailable from GPs in three health authorities, while GPs in eleven other authorities employed the services of just 25 counsellors between them – to serve a population of over 5 million. [14]

The lack of suitable training (fewer than 50% of GPs have undertaken a hospital psychiatric post as part of their training), the continuing large proportion of single-handed GPs in London, and the pressure on primary care services which has reduced the average consultation time to 5 minutes all serve further to restrict the scope for GPs to play a much greater role in the delivery of mental health care.

Practice nurses are even less likely than GPs to have had appropriate training, and there are also neglected training issues for other front-line support staff (receptionists, etc.) who must play a key role if mental health is to be integrated more closely into primary care.

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Building on users' experience

One sector of society to whom the service has remained least accountable has been the users of mental health services. Reams of rhetoric over the last 15 years about patient-centred services and placing users at the centre of new developments have barely disguised the fact that services have remained constrained by resources rather than led by needs, and dominated by the medical profession rather than shaped by patients.

Although there may be ritual obeisance to the notion of "user empowerment" in abstract strategy documents and Trust Annual Reports, when it comes to the nitty gritty of health authority purchasing plans, wrestling with budgets and outlining proposals for the coming year, the balance sheet rules. Few HAs in practice model their plans on the wishes

or needs of patients or their relatives and carers.

There is no doubt that fuller utilisation of users' experience of the current service would be a valuable resource in filling the gaps and tackling chronic problems of communication, access and responsiveness.

The Mental Health Task Force report in 1995 found alarming symptoms of a fragmented, inadequate system of care: "We found that when people are in crisis they are most likely to receive assistance from the Police, Social Services Emergency Duty Teams, or to present at Accident & Emergency Departments. The A&E departments were found during the first round of visits to be unsatisfactory places for receiving people in crisis." [21]

The Task Force went on to claim that progress had been made on the physical environment and staffing of some A&E units: but the financial pressures on Trusts since 1995 have meant that front-line services have been forced to apply ever-more exclusive criteria and thresholds in targeting care only at the most seriously ill.

In 1990 a survey of the views of over 500 service users on the quality of care they had received showed widespread dissatisfaction. 101 out of 124 comments on hospital treatment were negative, while less than half of respondents found day services helpful. The most positive views were on the value of "talking treatments" rather than tranquillisers or ECT. [58]

In 1994 a survey by Mind in Islington, interviewing 103 mental health service users, showed a less negative view of in-patient care, with two thirds finding it either helpful or very helpful. Most users also welcomed the idea of a 24-hour crisis service, which they wanted to be accessible, immediately available and able to give personal support, with someone to talk to. As a result of the survey two crisis centres were opened by Islington social services. [59]

In the same year a survey of user views at the Bethlem and Maudsley hospitals found that while most in-patients (96 percent) thought hospital staff were "very" or "fairly" helpful, a large majority (70 percent) felt they were not given sufficient explanation of the Mental Health Act. Over half said they would like more contact with the outside world while in hospital. [60]

In 1995, a survey of black and Asian mental health service users in Waltham Forest found 15 out of 23 giving favourable opinions of day centres, while only 4 out of 31 reported good treatment as in-patients, against 19 who were unhappy with the treatment they had received. Complaints included: "keep getting beaten up by patients and staff", and "Had to take whatever medication and dosage were prescribed. It was useless to complain". [61]

In 1996 a Mind survey of 112 mental health service users in Barnet also found a much more positive evaluation of community-based services than those delivered in hospital, and 97 percent felt that having an advocacy service available for service users was important. One service user summed up the problem:

"When patients are in hospital they have no say about their care. Their views are disregarded. They are at the mercy of the staff. The staff do not always know what is best for the patient." [62]

More recently, surveys of service users have emphasised continuing problems of access to care, especially in crisis situations. A survey of 3,000 people for the Mental Health Foundation revealed widespread confusion on who should be contacted for help if they, a friend or a relative needed urgent help. [63]

And a survey of 2,000 service users, professionals and carers conducted by the National Schizophrenia Fellowship showed that over a third of service users had been turned away by services when seeking help, and a quarter had been refused hospital admission. More than two thirds thought that a new legal right to adequate care and treatment would be the biggest improvement a new Mental Health Act could offer. [8]

There is no doubt that fuller utilisation of users' experience of the current service would be a valuable resource in filling the gaps and tackling chronic problems of communication, access and responsiveness.

"When patients are in hospital they have no say about their care. Their views are disregarded. They are at the mercy of the staff. The staff do not always know what is best for the patient."

So great is the concern at inaccessible and inadequate services for those in need, and at the quality of hospital care, that 58 percent also felt that compulsory treatment in the community would be a good idea and preferable to being sectioned.

Endless inquiries

The patchy and inadequate care of patients under the present system has left room for a grim succession of tragic events, including suicides and murders, many of which have been followed up by lengthy inquiries drawing scathing conclusions on the gaps in care. Last November London's health chiefs were conducting no less than ten inquiries into killings by people with mental illness. [64]

The latest report of the National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness points to suicides by mental illness sufferers running at 1,000 a year, and murders at an average 3 per month. [55]

Like many of the specific investigations into cases – such as that of Christopher Clunis in north London, or the 600-page report on the care of Luke Warm Luke in south

More recently, surveys of service users have emphasised continuing problems of access to care, especially in crisis situations

No questions asked, no lessons learned from Robert's death

Robert was found dead early on a Sunday morning. The hospital "could not find" a family contact number, although the clinical psychologist had telephoned his sister and spoken to her 4 days previously. Police informed his sister of Robert's death on the Tuesday afternoon, and I went to be with her.

The Police gave us the name of the ward sister. I rang her and she gave me "all the details" over the phone without any hint of compassion.

I collected Robert's belongings from the ward. They did not ask who I was, or whether I had permission to collect his things. Gill had particularly wanted Robert's watch – it was about all he had to leave anyone. There was no watch at the hospital. It is not hospital policy to inventory patient's belongings when they are admitted. The staff were quite offhand.

Gill and I went to the inquest on February 11. The inquest had been delayed 3 months waiting for the hospital internal report. We had not seen the report.

Robert's "named nurse" was not at the inquest, but had been "excused". His psychiatrist did not arrive, despite having been called as a witness. The Coroner said Gill could postpone the inquest if we wanted to question him about the report we had not seen.

We were given a couple of minutes to read it as the inquest began. The young nurse who found Robert was there: he admitted he had not really spoken to Robert as he was not his nurse.

No-one else from the Trust or hospital was there. It took 25 minutes to investigate Robert's death, yet it appeared unworthy of representation from those who should be held accountable.

The Coroner was going to pass an open verdict because it could not be proved that Robert had intended to take his own life.

Robert had "borrowed" a belt from a patient, and had a second one in his pocket. He had locked himself in the shower room and tied one end round the shower head and one end round his neck: what else could he have been trying to do? The Coroner said that he had not left a note, nor "told anyone" he was planning to kill himself.

Robert had been admitted following an overdose (there had been a suicide note on that occasion two weeks previously).

He had told me the day before he died that "This was worse than death itself" and he would end it all the first opportunity he got. Having sworn to this at the inquest, the verdict passed was of suicide.

The hospital report said nothing. It did not answer why he languished in the local general hospital for 12 days without anti-depressants or counselling, waiting to be transferred to Warley.

It referred to Robert's previous suicide attempt and time in Warley some 10 years earlier, and seemed to use that information as the basis of their assessment.

The doctors felt he was no longer suicidal. If anyone had listened to Robert's problems they would soon have felt that he really had very little in his life to look forward to.

No mention was made of why they could not contact his family, or about his watch.

Nothing was said about why the newly-refurbished shower room had been fitted with a weight-bearing fixture.

If an open verdict is passed, the hospital has no suicide on its records. On December 3 another patient hung himself – an open verdict again means the hospital can forget about it.

At no time from the time of his death to after the inquest did anyone from the Trust contact Robert's family in any way.

We did not expect an apology – that would be too much to ask: but some acknowledgement, some sympathy, some compassion would have been nice.

(Letter to London Health Emergency, March 1999. Full name and address supplied)

London – the new report offers a list of 31 recommendations, centring on the objective of more closely linking hospital and community care services to ensure that high-risk patients can be followed up after discharge.

However with unrelenting cash constraints and pressures on staff in front-line services – both NHS and social services – it seems unlikely that many of these recommendations can be consistently carried out, or real root and branch changes made.

The focus always tends to be upon the headline-grabbing murders, with relatively little attention to the far higher number of suicides and deaths of patients, not least in psychiatric hospitals. The reluctance of NHS Trusts to tackle problems of suicide, and the difficulty in making anyone accountable to service users or their families is graphically underlined by the letter received by London Health Emergency following the third suicide in Warley Hospital in six months. (See Box)

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There have been many more local inquiries, including one into seven suicides at the West London Healthcare Trust. It seems now that the National Confidential Inquiry team, and the Department of Health, are tiring of the constant stream of reports which seem seldom to lead to substantial, structural changes and improvements. Their latest report calls for an end to mandatory local inquiries into killings by mentally ill people, arguing that formal investigations perpetuate a "culture of blame" and are of doubtful value. [65]

It is hard to see how failing to investigate cases can produce any more radical solutions than carrying out systematic investigations. The burden of most of the inquiry reports to date is that rather than blaming individual, over-stretched care workers, more searching questions need to be put about the ramshackle, leaky system in which the care of people with mental illness is carved up between under-funded health, social service and voluntary organisations.

London Regional Office: all change?

One of the changes which we have been promised from the new London Regional Office of the NHS is that the views of mental health service users and their organisations will be taken more seriously in the planning of services across the capital. However there is much ground to be made up. Even where there is an explicit commitment to "partnership" it can be hard for user groups to get a proper hearing.

Southwark CHC recently wrote to Frank Dobson to protest at the fact that Lambeth, Southwark and Lewisham HA had refused to allow either the CHC or other user groups to participate in its so-called "Mental Health Partnership Board". Instead the "Partnership" appears to be restricted to health and social care agencies. [66]

There are similar complaints about the exclusion of community, voluntary and user groups from the work of the Health Action Zone in East London. According to Hackney CHC, none of the 90 people who had signed up last autumn to participate in the proceedings of the HAZ had been contacted by the Board six months later. The sole voluntary sector representative on the Board has said that at the moment the HAZ, which is supposed to blaze the trail for partnership on health, is all gloss with no substance. [67]

Despite the obvious good intentions of its mental health team, occasional London-wide gatherings convened by the London Regional Office cannot substitute for the day-to-day involvement of service users at local level by Trusts and Health Authorities. The extent to which the new Regional team can exert any authority over local NHS management across the capital and open up a genuine London-wide drive for improved services has yet to be proven.

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User groups' demands

The 1994 Charter produced by the Mental Health Task Force User Group and endorsed by a conference of 200 service users and survivors set out ten main headings, in which prominence was given (among other items) to:

- Personal dignity and respect,
- Information,
- Accessibility of services,
- User participation and involvement in planning care,
- The right to choice and to advocacy
- and to have complaints speedily and impartially investigated.

Although a diluted form of this Charter formed the basis of the last government's NHS Mental Health Services Charter, many of the rights sought by service users place additional demands on resources, and have yet to be fully realised in a cash-strapped service. Perhaps the most central, underlying point running through all ten demands is that mental health service users themselves, their wishes, needs, views and preferences, should be taken seriously and made central to the planning and provision of services.

This echoes the first demand from the first national conference of Survivors Speak Out in 1986, "That mental health service providers recognise and use people's first hand experience of emotional distress for the good of others". Thirteen years later it is vital that this point is taken on board by mental health service planners and providers. [68]

Perhaps the most central, underlying point running through all ten demands is that mental health service users themselves, their wishes, needs, views and preferences, should be taken seriously

At the sharp end: mental health staff

UNISON is the largest union representing staff in mental health. But it also recognises its responsibility to uphold the professional standards of its members, and to defend the quality of service which can only be achieved through maximising the involvement and empowerment of those who use mental health services.

UNISON first raised these issues in the run-up to the 1997 general election. We believe these vital questions of policy, and the proper resourcing of mental health services must be made a priority for the next five or ten years.

The new government must go beyond the general propositions of ***Modernising Mental Health Services***, and inject substantial new money – capital and revenue – into London's mental health services if they are to end the crisis and confusion created over the last 10-15 years.

The experience

This chaotic and under-resourced situation is the ***real*** "spectrum of care" on offer to mental health sufferers: a spectrum often ranging from very little to no care at all. Scarce resources are "targeted" to exclude any but the most severely ill, leaving a choice between under-resourced and intermittent care in the community or the prospect of life on what are often grim, frightening and violent pressurised acute and admissions wards.

Such conditions offer few satisfactory choices to users seeking mental health care, but they also compound the misery for staff at each level, not least for nursing staff and other professionals on the front line. They see their skills and training increasingly reduced to "door duty", attempting to pacify and defuse the frustration of patients on crowded wards.

All this is very different from the positive vision of community care, properly resourced and with the central focus on the needs of the patient, which eventually broke down the initial conservative resistance to change within the medical profession and the health unions.

It was the positive commitment to improving the quality of care, making it more local, accessible and tailored to the requirements of each individual client which began to overcome the natural suspicion that the big hospitals would simply close – without the

necessary development of alternative, superior services in each community.

Unfortunately that trust was abused by the last government, and the vision has in much of London been shattered by a reality of a desperately under-resourced service. Instead of the necessary investment in staff, in adequate premises, in training and retraining for the new demands of work in smaller units and in the community, there has been a consistent attempt to cut services to fit budgets, and to ration care to those with the most severe symptoms.

Discussion of problems caused by the underfunding of London's mental health services often focuses on acute wards and bed shortages. However, these are inevitably linked with the difficulties experienced by community mental health staff. Few Trusts have set up the type of innovative initiatives favoured by many clients as alternatives to hospital, such as home treatment services or crisis houses. This leaves community staff attempting to contain potentially unsafe people (almost always those presenting as a self harm risk) even when their own clinical judgement tells them they should be seeking a hospital admission as the safest course of action.

Few Trusts have set up the type of innovative initiatives favoured by many clients as alternatives to hospital, such as home treatment services or crisis houses.

Equally, people being discharged or sent on leave prematurely have to be picked up by community staff, whilst the contemporary practice of having nurses as nominated keyworkers places a lot more responsibility on the nurse than would have been the case some years ago, ironically when there was easier access to hospital when necessary.

The risk of violence is always present for community staff, particularly when undertaking new assessments, and few Trusts insist on safety policies that include home visits to unknown clients being undertaken by two members of staff and supplying mental health workers with mobile 'phones and personal alarms.

Community mental health nurses often relish the semi-autonomous nature of their work. However, too often this reflects relative isolation, when a community mental health "team" is forced by pressure of work, poor working practices and training, into becoming a group of individuals working their own caseloads with little time or opportunity for reflection, supervision or the forging of any collective identity.

Psychologically, emotionally and often physically cut off from peer support, stress levels inevitably rise. Safety is inevitably a major concern and not helped where inadequate procedures are in place. Where joint visits are advisable or necessary, this usually only adds to the workload of the second nurse involved. The intensity of the relationship between a keyworker and client can also become a real burden when there is insufficient support, particularly where there are long standing concerns about safety.

The number of people on a caseload has an obvious effect both on the worker and the care they are able to offer. Mental health care, from problems to solutions, another piece of research from the Sainsbury Centre and the NHS Federation, found that in almost half the Trusts surveyed CPN caseloads were 45 plus, with 13% employing CPNs holding a caseload of 65 plus. [69] There have been reported case-loads for CPNs as high as 120 recorded in different research projects [70]. Not only are these patently unmanageable, they are completely unsafe.

A sample survey of eight inner and outer London Trusts for this report early in 1999 found CPN caseloads ranging from a low of 20 to a high of 45-50.

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As well as their own individual caseloads, many CPNs also have responsibilities related to crisis duties and out of hours on call services. Managerial demands for an extended role, extended hours and extended patience are not matched by extended pay scales – and have usually been added on to existing services without additional staffing.

Equally, few community mental health services have made any serious attempt to establish proper teams. Rather, they have gathered together groups of staff who are provided with little in the way of managerial or clinical leadership, and who do not have safe and containing structures within which they can develop their individual clinical

practice or share skills and experience.

The cornerstone of developing good practice in community settings must be a culture of openness, bringing people together routinely for supervision and support and shared, multi-disciplinary training. Managers rarely make this a priority, however, instead adopting a strategy of reacting to the "last but one crisis". There also seems to be an anxiety about letting nurses and other clinicians work together – perhaps for fear that they may actually develop a collective identity, recognising the mutuality of their interests, and start articulating their demands effectively.

Staff shortages

Statistics and generalised examples of the difficulties facing mental health workers are translated into case histories of unmitigated misery for the people who rely on services. For those given the responsibility of service delivery it is a constant struggle. In our inner cities, the pressure has resulted in the inability to retain staff, recruitment crises and consequent reliance on inexperienced, junior staff and agency nurses to take on increasing responsibilities and workload.

One inner London mental health Trust surveyed by its local UNISON branch revealed 88% of respondents reporting increased workload from the previous year, 77% experiencing increased stress levels, and 60% – unsurprisingly – suffering low morale. 39% reported that staffing levels had deteriorated over the previous year and 35% had been involved in serious incident in their workplace. Significantly, 36% stated that their manager's treatment of staff was bad enough to make them want to leave, which raises yet another problem.

Vacancy rates reported in a partial survey of nine Trusts for this report early in 1999 ranged as high as 36 percent for qualified nursing staff, with some Trusts also finding problems in recuiting and retaining Occupational Therapists – with vacancy rates as high as 55 percent. By contrast the same Trusts reported huge pressure on acute beds: only one (95%) was below 100%, while others ranged as high as 139%.

Most NHS staff report that they are badly managed, and this can only compound the serious problems facing those working in mental health. Even more worrying is that those who find their responsibilities mushrooming have no authority to resolve the problems they face, something confirmed by this particular survey. It is perhaps ironic that staff in what, historically, was the best unionised and most radical part of the NHS now tolerate such conditions.

Staff do not make sufficient use of either unions or professional bodies to try and redress the situation. Nurses themselves run the risk of falling foul of the UKCC's Code of Conduct when they are called upon to participate in unsafe practice or unable safely to fulfil their duty of care. But very few, if any, mental health nurses will cite the UKCC Code as a means of supporting their right to say, 'No,' when asked to admit people in what they assess to be unsafe circumstances, or take a new client onto their caseload, even if they are already overstretched.

This probably says a lot about the way the UKCC is perceived as an unhelpful bureaucracy by nurses. Nevertheless UNISON – through the booklet, ***Be Safe: A UNISON Campaign For Better Standards of Care*** – has actively encouraged nurses to speak out against poor and unsafe standards of care. [71]

Nor should we ignore the problems raised by the provision of mental health services in the smaller hospitals that have taken the place of the Victorian "bins". Although the hospitals may in most cases be more

Vacancy rates reported in a partial survey of Trusts for this report early in 1999 ranged as high as 36 percent for qualified nursing staff

Acute bed occupancy rates, 1999

TRUST	OCCUPANCY
Barnet Healthcare	95%
Royal Free	100%
Bethlem & Maudsley	102%
Oxleas	109%
Redbridge Healthcare	109.7%
Enfield Community	116%
Hillingdon Hospital	122%
Lewisham & Guys	130%
Lambeth Healthcare	139%

local, patients in these smaller hospitals are not living in "the community", but in smaller institutions. Few of these smaller units have any substantial grounds, or sufficient free internal space for patients. The reduced number of beds available also means that these often cramped units are crammed with a concentration of people, all of whom have the most severe problems, while any with less serious symptoms are likely to receive little if any support.

The smaller scale of the hospitals also means that there is less density of staffing to cover difficult periods, and the more intensive working conditions has meant increasing difficulty in recruiting and retaining the necessary skilled nursing and other staff vital for quality care.

Training issues

Working in London's mental health services has changed beyond all recognition in the past decade. Reported workloads, responsibility and stress levels have risen virtually everywhere they have been surveyed. Staffing levels and morale have almost always fallen. The capital's services bear little comparison to those in the provinces or even other cities. The difficulties and pressures are particularly felt by frontline clinical staff such as nurses and occupational therapists, for whom UNISON is the major trade union.

The UKCC Code of Professional Conduct (clause 3) reminds nurses that they are "personally accountable for (their) own practice and, in the case of (their) professional accountability, must maintain and improve (their) professional knowledge and competence". [72] Particular emphasis is placed on post registration training and evidence based practice. This is a tall order, indeed, in contemporary mental health services, where the pace of change has been both frightening, bewildering and much of it, in reality, dictated not so much by evidence as affordability.

Increased responsibility and accountability is being placed upon the individual nurse with no concomitant authority or status – nor any guarantee of access to improved training. This can often mean that good employers will ensure nurses and mental health workers get proper training whilst the less good – where training is often needed most – do little or nothing.

The importance of training is dramatically underlined in the ***Report of the Inquiry into the Treatment and Care of Gilbert Kopernik-Steckel***, in which the story of a desperately tragic but unnecessary homicide and suicide compellingly unfolds (and should be compulsory reading for all mental health practitioners). Paragraph 3.3.10 states:

"Nursing staff training was haphazard and lacking an overall strategy based on the training needs of individual staff and relating to their roles and responsibilities. Staff on Woodcote Ward [an acute admission ward located on a District General Hospital site] were not routinely trained in techniques for dealing with behaviourally disturbed patients, including safe techniques for physical restraint. The same situation applied to training in the use of the MHA.". [73]

A recent report into the training needs and role of mental health nursing staff concludes that there is a serious disparity between existing training arrangements and the actual needs of the service, both now and in the future. Whilst this focuses on nurses working in the community, the same is true for staff working on acute wards. [74]

In the inner cities, most patients will be formally detained on a section of the Mental Health Act, with levels of distress and disturbance far greater than ever before and much nursing time being spent on 'creating' beds. This is done in a variety of ways,

Increased responsibility and accountability is being placed upon the individual nurse with no concomitant authority or status – nor any guarantee of access to improved training.

"Employers have a duty to provide the resources needed for client care. You will need to highlight concerns about safe staffing levels, skill mix and working practices when they impact upon client care. This may present particular difficulties if your line manager is not a registered nurse and insists upon a particular course of action. You should be familiar with local procedures for raising concerns and you may feel it necessary to discuss these decisions with other colleagues or your professional membership organisation."
(from UKCC *Guidelines for Mental Health and Learning Disabilities Nursing*, para 22)

including discharging people before they are ready or transferring them to another part of the service or even another hospital.

An alternative to this is the so-called "hot-bedding" procedure of sending one person on overnight leave to accommodate a new admission. In some cases, patients have been required to sleep in armchairs overnight, or extra, temporary, beds have been placed in non dormitory areas. It is these practices that create bed occupancy rates of 100% plus.

Not only is this practice unprofessional in every sense of the word, it is also dangerous for staff in a number of ways, placing them in a vulnerable position with rightly aggrieved clients being asked to vacate their bed, leaving them with more than the designated number of clients in their care, sending people out of hospital before they are ready and, not least, because it goes directly against the UKCC's code of conduct.

The most notable problem this practice creates for nurses working on acute wards is the undermining of any kind of therapeutic relationship. Trust and confidence cannot be developed when the patients does not know where they will be sleeping that night. Nor can it when they may have to stay on three wards during one period of admission, with those wards not necessarily being in the same hospital.

Nurses have little opportunity to spend enough time with patients to make many therapeutic interventions, and there is some evidence to suggest that they are not confronting anti-social and potentially dangerous behaviours. Pressures on staff mean that the real origins of patients' complaints about a lack of safety and/or abuse are ignored. As well as the effect on users, it inevitably affects clinicians, undermining morale and confidence.

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All of this, combined with a lack of training in new techniques, will inevitably lead to a de-skilling of contemporary acute nurses who, in turn will then be unable to pass on any useful practical skills to future nurses – current students – joining their teams.

In fact, nurses are having to get to grips with an increasingly complex role which has changed extensively with the decline of input from social services and broader welfare services and support staff (in areas such as housing, benefits advice and employment). These have all had to be incorporated into the ambit of the nurse, who also holds the role of being the key healthworker in the transition from hospital-based care to services provided in the community. Often this has occurred without any specialist training.

For instance, nurses now have an increasing role in the assessment of people newly referred to community mental health centres. In some cases, a psychiatrist will never actually see the patient. This means that the nurse's assessment is crucial. Yet undertaking this kind of holistic, comprehensive assessment is a relatively new skill for the nurse that few will have been taught methodically and as a part of their ongoing professional and service development.

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It is clear that the post registration training programmes within Trusts are as patchy and inconsistent as the provision of services for users. Where it has been available, training has often failed to keep pace with the still-changing clinical, political and social settings nurses are now working in and most has focused on community working. There is a plethora of expensive courses available on topics such as risk assessment, working with clients who self harm, dual diagnosis work, and cognitive behavioural therapy (CBT) techniques for a variety of mental health problems, most notably schizophrenia.

Yet nurses undertaking such training rarely obtain a reduction in caseload and adequate time off. The managerial notion that nurses and other mental health workers can undertake any amount of new work on top of what they're doing is an absolute nonsense.

It is now clear that a community mental health nurse shares more, in terms of core skills and competencies, with social workers and community occupational therapists working in mental health than with a staff nurse working on a surgical unit. Certainly, the

possibility of exploring a specialist mental health nurse training, with shared modules and a shared educational pathway for OTs, social workers and nurses must be on the agenda in the near future at the very least.

The massive gap between current training arrangements and service needs – both now and in the future – must be addressed, while training initiatives need to recognise and reflect the different needs of staff working in primary care, in patient units and the community.

Issues for social workers

The issues for social workers are similar, in some respects, to those facing nurses. In others they are vastly different. Social workers face many uncertainties around their role and training as their services are become linked more closely to health. Where 'joint' services are being set up, the fear for many is that they are being subsumed into health with little preparation and at the risk of losing their professional identity. There are similar issues around greater responsibility and increasing workload, without the necessary authority to make key decisions.

As these changes occur there has not necessarily been appropriate training provided, which means that problems related to role definition, taking on new areas of work and working within multi-disciplinary settings are not easily resolved. There is undoubtedly as large a training agenda for social workers in mental health as there is for their nursing counterparts.

Moreover, whilst nurses have largely escaped the media's wrath, the tabloid press and sections of television and radio media picked up on the Tories' anti social work propaganda, effectively demonising the profession in some cases.[75] A recognition of these problems can lead to tensions between health and social services' workers, with a reluctance to work together.

Managers who don't do the necessary groundwork and involve staff in planning and decision-making inevitably risk important projects failing even when those involved have the best intentions. Social workers are also inevitably subject to the vagaries and vicissitudes of local government spending, affected by capping, government grants and political changes in the ruling party. Thus, long term planning has been no easier than it has for those working in a market-dominated NHS.

Within Social Service budgets there is also, understandably, lobbying for extra cash from different departments. And with mental health not high on anyone's agenda, it is this part of the service that has suffered in recent years, particularly in the inner cities where people's needs have increased most dramatically.

Budgetary constraints are often felt most pointedly in the areas of recruitment and retention. In the inner cities these are particularly bad, meaning that safety procedures are often even less rigorous than they are for those working in health. The serious risks run by social workers in mental health as part of their day to day duties are entirely unacceptable – even more so when it is considered that a great many of them are employed by Labour-controlled authorities.

Nonetheless, despite, or perhaps because of, these problems, few would dispute that closer working, joint practice or even merged services would be to the advantage of the client, lead to an improved service and improve the sharing of skills experience and expertise. The hurdles that will have to be cleared are enormous and, given the scale of the problems facing those working in mental health social services, very careful consideration needs to be given as to how a progressive agenda can be developed and implemented.

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UNISON

John Lister
(incorporating additional material from Chris Hart and Jim Read)
May 1999

Mental Health Workers' Charter

MENTAL HEALTH services in London are at breaking point. Acute wards are bursting at the seams, with soaring occupancy rates, while community teams struggle with unmanageable caseloads.

Staff morale has never been lower, and shortages of sufficient qualified staff jeopardise the quality of patient care. Neither health authorities nor Trusts – each of them facing intense financial pressure – appear willing to take any stand in defence of the quality of services, let alone fight for the massive injection of resources that is needed to repair the accumulated damage from two decades of under-funding.

UNISON is putting forward these proposals for discussion as an agenda for action to stop the rot and begin the rebuilding of mental health care, hopefully in alliance with mental health service users and any sections of Trust or Health Authority management who recognise the need for wholesale change if a quality service is to be built in London.

Hospital services

* IMMEDIATE measures and additional resources to reduce average acute bed occupancy levels to a maximum of 85%. This to be done by a combination of enhancing community mental health services (especially 24-hour crisis intervention), establishing 24-hour nursed accommodation, innovative home care and user-led services, and, where necessary, additional in-patient beds.

* PHASE OUT by April 2000 the use of private beds for NHS Extra Contractual Referrals, which is siphoning millions from London's mental health services.

* FINANCIAL resources and a firm timetable in each health authority for the establishment of adequate 24-hour nursed accommodation for adult continuing care.

* SUFFICIENT staff to ensure wards provide a supportive, therapeutic environment for people at various stages of recovery, offering a structured day of activity and treatment.

* INCREASED numbers of permanent, full-time nursing and support staff to improve continuity and quality of patient care. ENHANCE skill mix with an increase in more experienced and better qualified nursing staff . Staff:patient ratios to be agreed and upheld for each ward.

In the Community

* AN EXPANSION of CPN numbers and Community Teams to reduce maximum caseload to 20 – or lower for more seriously ill patients.

* STAFF numbers to be sufficient and rotas to be organised to prevent individuals conducting high-risk home visits and crisis intervention alone.

* MOBILE phones and personal alarms to be issued to all staff conducting community visits.

Stop and control violence

* WARDS and Community Teams to conduct regular risk assessment, and to develop strategies to reduce the threat and possibility of violence against patients and staff.

* ALL nursing staff – hospital and community-based – to be trained in managing conflict, defusing violence, and in safe methods of control and restraint.

* VIOLENCE against nursing or support staff to be regarded as seriously as violence against doctors. Trusts must organise systematic support, including counselling where necessary, for staff who are victims of violence.

Training

* AN URGENT review of the content of the P2000 course for mental health nursing, with specific reference to the implications of the Mental Health Act and the pharmacology of psychiatric medicines.

* IMMEDIATE changes to ensure that P2000 graduates receive practical training in acute wards and in community teams before taking charge of any front-line services.

* URGENT steps to establish and fund specialist training courses for community psychiatric nurses, open to staff wishing to transfer from hospital setting.

Quality monitoring

* AN OBLIGATION on commissioning bodies (health authorities and Primary Care Groups) to specify and monitor maximum bed occupancy and staff:patient ratios, maximum CMHT caseload, and numbers of continuing care places in 24-hour nursed accommodation.

* AN OBLIGATION on Trust Boards and management to ensure that resources, staff and bed numbers are sufficient for professional standards of medical and nursing care to be provided.

* AN OBLIGATION on nursing's professional body, the UKCC, to investigate complaints by mental health staff of any management policy leading to a breach of the UKCC's Code of Professional Conduct.

* THE RIGHT of mental health workers to demand outside investigations or inquiries by one or more of the following external bodies into services which fall below acceptable quality and safety standards, or into violent or untoward incidents which have not been dealt with satisfactorily by management:

- Mental Health Act Commission
- Hospital Advisory Service
- Health & Safety Executive
- Community Health Council

* THE RIGHT of mental health workers – with due regard for patient confidentiality – to publicise serious shortfalls in the quality of mental health services.

* THE RIGHT of mental health workers to take appropriate industrial or other collective action if necessary to challenge unsafe working practices, inadequate staffing levels, or inferior quality care.

Resources

* THE PROBLEMS of London's mental health services stem from two decades of under-funding. To restore staffing levels and bridge the gaps in care which have opened up will inevitably cost more money.

UNISON calls for an injection of £100 million in capital over the next three years for new 24-hour nursed accommodation and for expanded community mental health services in London, and £100m additional revenue spending per year to run these services and allow mental health Trusts to increase staffing levels and reopen beds if necessary to reduce occupancy levels.

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The Care Gap

Contents

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