**NHS London**

# Healthcare for London: a framework for action in mental health

## Briefing

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# 1. Background and context

1.1 There have been dramatic changes in London's mental health services over the last 20 years, which in many respects prefigure the radical realignment of acute physical healthcare currently under discussion. The system based on very large inpatient institutions offering only limited outpatient services as an adjunct to inpatient treatment is now obsolete. Instead, mental health care is based on the premise that care for serious mental illness is best delivered to people in their own homes, with medical and other care staff working in multidisciplinary teams in community settings. Admission to hospital is a part of the system, rather than its core.

1.2 More recently services have been further developed for young people, adults and older adults that aim to intervene as early as possible in the course of illness to improve long term prognosis, to maximise independence and life choices for service users. These services aim also to improve cost effectiveness, not just for health services, but also for social welfare, for education and work and for the criminal justice system.

1.3 At the same time, across the developed world rates of mental illness are rising, and the problems of high need are particularly severe in large global metropolises like London.

1.4 The rise of substance misuse in particular plays a major role in the challenges faced by realigned mental health services; at times, they have struggled to keep pace.

1.5 The interface with the criminal justice system is also a significant driver of cost. National policy rightly dictates that those in the criminal justice system should receive the mental health treatment they need in an appropriate setting - but rates of offending are higher in major cities and the result is increased demand in the highest cost sector of care.

1.6 Mental health has a national blueprint for service development, through the National Service Framework and subsequent policy initiatives. The current challenge for mental health services is to put the full range of services and approaches into practice, to meet local needs whilst adhering to national policy and to advance knowledge and practice in response to rapidly changing and increasing demand.

1.7 Any strategic thinking must include partnerships. Mental health, illness and wellbeing are not solely health, or specialist health service, issues. A mental health strategy must involve the wider health sector, social services, education, housing, employment, criminal justice system, voluntary and community organisations.

**Spectrum of care for mental health in London**

1. In 2002/03 there were over 26,000 psychiatric inpatient admissions for London residents and 455,000 outpatient appointments. Compared to England London has significantly higher rates of psychiatric admissions [2].

2. London has a considerably higher percentage of inpatients with psychotic (schizophrenia, schizotypal and delusional) disorders (23%) compared to England (14%); the figure for London rises to over 30% of admissions in some PCTs [3]. Further, London has the highest rates of compulsory admissions to NHS and private hospitals under the Mental heath Act (1983) compared to the rest of England [4].

3. London has a higher number of psychiatric beds per 100,000 of the population than England, 86 compared with 65 beds per 100,000 in 2003/04. However, London still had a higher bed occupancy rate than England during this period, 91% compared to 88%, suggesting a greater pressure on acute mental health beds in London [5].

4. Deprivation is closely linked to use of inpatient services in London. Statistical analysis has shown that socio-demographic factors can explain 73% of the variation in the number of bed days per year and 60% of the variation in admissions per 100,000 across London [6]. Further, London inpatients are more likely to be from deprived wards than England inpatients [3].

5. There is overrepresentation of people from black groups in inpatient mental health and forensic services, and black patients are more likely to be detained under the Mental Health Act and to follow more coercive and complex pathways to specialist care. Further Black Caribbean inpatients are more likely to be diagnosed with psychosis, including schizophrenia [7].

6. London has a consistently higher use of forensic service beds than the rest of England; a fifth of all medium and low secure inpatient beds across England are for London residents, and a third of all patients in the three secure hospitals are from London. There are plans to increase the capacity of London's forensic inpatient services by over 50% [4].

7. The spectrum of care is continuing to expand through the implementation of the National Service Framework for Mental Health. In March 2004 there were 139 Community Mental Health Teams (CMHTs) in London with a total caseload of over 36,000 people. There were also 43 Assertive Outreach Teams and 31 Crisis Resolution Teams in London. Crude caseload figures

suggest that for all of these services/teams London has a higher average caseload per service/team than England [8].

8. It is estimated that 90% of people with mental health problems are cared for entirely within primary care [9]. However, pressures on primary care services and the closure of some General Practitioner (GP) lists present access barriers, particularly for vulnerable groups. In one PCT, up to 30% of the population in some parts of the borough were not registered with a GP [10].

9. London has a lower number of local authority or registered home service placements per 100,000 than England (177 compared with 194), but a higher rate of supported housing service placements (36 compared with 27 per 100k) [8]. However in some boroughs there are significant numbers of people in hospital waiting for appropriate accommodation with delays in the moving-on process occurring due to gaps in existing provision, especially for specific groups or needs. Shortages in appropriate housing locally mean that some people are housed outside of their borough [11].

**TABLE 1**

## 2. Conditions for change

### 2.1 London's distinct population presents unique challenges for the Capital's mental health services

2.1.1 London and its population are unique in the UK. London has a rich, ethnically diverse population with over 300 spoken languages and large populations of refugees and asylum seekers (1). Language barriers in London are self-evidently critical in the delivery of mental health care and asylum seekers and refugees are at increased risk of mental ill health.

2.1.2 There are pockets of great social deprivation in London with some of the most deprived Local Authorities in the UK, high homelessness rates and high unemployment rates. Social deprivation and homelessness are associated with increased risk of mental health problems. Employment acts as a protector in relation to mental health and has been shown to promote recovery for mental health problems.

2.1.3 London's population is relatively young compared with the rest of the UK. Mental health problems in young people have health, social and economic consequences; for example, children with mental health problems risk losing out on education and training, which in turn increases the risk of later unemployment and further problems later in life. It has also recently been highlighted that more children in the UK are living in poverty, with some 400,000 children in London existing in extremely poor housing; both increase the risk of mental health problems.

2.1.4 Although London's population profile is younger than the average, the expected increase in older people nationally, and concomitant mental health pressures, will be experienced proportionately in London.

2.1.5 Other critical characteristics of London are its mobility and rapidly changing community patterns (for example, it has been forecast that outer London will soon take over from central London as the most important region for minority ethnic communities). A recent London Assembly report described how London's mobile population makes seamless service provision extremely difficult.

2.1.6 A paradox inherent in the character of London as a city is that its very strengths are also the source of its weaknesses (London Project Report, PMSU, 2004). It is a city which excels in the industries of the mind: finance and business, academia and research, media and the arts, government and politics. At the same time, the conditions which sustain and support that flourishing – the pace of life, the diversity, and the stresses of urban living – pose some of the greatest challenges to maintaining mental well being. London lives by its wits, so it must take care of them, just as much in good mental health care as in good education.

## 2.2 Londoners have complex mental health care needs placing higher than national average demands on services

2.2.1 Over a million people in London have mental health problems and mental ill health is more prevalent in London than in the rest of the UK.

2.2.2 International studies have estimated that the overall healthcare costs in capital cities can be upwards of 140% of the costs of other parts of the country; in London, the actual allocation of resources is approximately 105% of the costs of other parts of the UK.

| **Spending on mental health services** |
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| 10. Expenditure per capita on mental health services is substantially greater in London. In 2003/04 mental health investment per head was £144 in the capital compared with £123 across England [12]. However, most London PCTs are spending less than their expected allocated funds for mental health, with some spending less than 50% of their resource allocation (2002/03 to 2005/06) for mental health [3]. |
| 11. It is difficult to assess whether the amount being spent is adequate for the needs of London or whether it is being spent on the right spectrum of care. Current spending patterns are heavily influenced by historic patterns [12]. |
| **TABLE 2** |

2.2.3 The mental health needs of Londoners vary across the capital. There is higher prevalence of mental health problems in some boroughs than in others; prevalence rates are strongly associated with deprivation levels.

2.2.4 London has a considerably higher percentage of inpatients with psychotic diagnoses (23%) compared to England (14%). People with a psychotic diagnosis constitute the largest group of those receiving treatment in secondary care, and their care consumes substantially the greatest share of resources.

2.2.5 London has the highest number of people per 100,000 population on the caseload of CMHTs and also the highest number on the caseload of assertive outreach teams.

2.2.6 London's large population of black and ethnic communities is an important factor in understanding service need and response. A recent, large scale study of first episode psychosis found that diagnoses of psychosis among African/Caribbean and Black Africans were five or more times greater than those found among White British people (ref: AESOP). African/Caribbean patients were more likely to be referred to mental health services via the criminal justice system rather than by GPs, to be perceived as a risk to others, and were less likely to seek help. Several studies have shown that black people are much more likely to be admitted to hospital under the Mental Health Act, compared with white people.

2.2.7 The prevalence of people with a dual diagnosis (mental health and drug or alcohol problems) is higher in London than in the rest of the country. One study has suggested that up to half of people in acute psychiatric wards in London were also substance misusers.

2.2.8 London has a large concentration of people in contact with the Criminal Justice System (CJS) with 8 prisons, including Feltham Young Offenders' Institution. High proportions of people in contact with the CJS have serious mental health problems, presenting specific pressures for the delivery, continuity and costs of care. For example, it has been estimated that 70% of prisoners have two or more mental health problems (Prison Reform Trust). The health care unit at Feltham has been described as "an acute forensic adolescent psychiatric unit". One study found that around 25% of costs in one trust could be attributed to a relatively small number of service users of forensic care alone.

## 2.3 London's mental health services have a more complex task in meeting needs and expectations

2.3.1 London's NHS structures and systems for commissioning and delivering services are complex, with 31 primary care trusts (PCTs). Following a period of considerable consolidation over the last ten years there are now 10 NHS mental health trusts providing networked systems of care across 31 boroughs in Greater London. At regional level lead PCTs also commission specialist care from London's mental health providers.

2.3.2 Not all London trusts provide every type of service and various specialties, treatment networks with specific responsibilities and centres of excellence exist in different parts of the system. Services, thresholds for and access to services therefore vary considerably and not necessarily as a planned response to varying need or social deprivation.

2.3.3 A recent GLA report on London's mental health described services as a "maze". Service users found it difficult to access services, experiencing problems in finding clear information, complicated referral routes and wide variation in services. However, once they were able to access care, the majority of service users were satisfied with treatment.

2.3.4 In line with government policy and a major shift nationally from hospital to community-based services, London has developed mental health services outside hospital settings and dramatically reduced inpatient stock. Nonetheless, acute bed occupancy rates have been very high for several years, and have exceeded those of all other regions. Length of stay is also longer in London and costs are high. Service users admitted to London mental health wards are much more likely to come from areas of high social disadvantage than nationally. The impact of drawing more of the most acutely disadvantaged and complex service users into sustained contact with services can be to increase acuity, creating a more volatile and disturbed ward environment. This can inevitably result in dissatisfaction with services.

2.3.5 The quality of inpatient care is variable; although there are many examples of vastly improved environments and better practice, inpatient care has not always been accorded sufficient priority for investment and improvement.

2.3.6 London has consistently used more medium and high secure beds per 100,000 people than any other region.

2.3.7 London also has the highest rate of admissions under the Mental Health Act (MHA), including the highest rate admitted to the independent sector.

2.3.8 The shortage of housing and high rates of homelessness in London put pressure on mental health services, with a lack of suitable accommodation being a common reason for severely delaying discharge from acute wards.

2.3.9 London's mental health services are facing increasing demands to deliver care to the large population of people with serious mental health problems in prison. At the end of 2005, there were 6551 people in London's prisons, but this underestimates the size of the demand, because the high turnover in London's prisons means that they are managing between 8-10 times their daily populations over the course of a year (Sainsbury Centre for Mental Health 2006). It has been estimated that up to 90% of prisoners suffer from at least one mental health disorder, and the rate of severe mental illness is up to 20 times greater than the general population (Farrell et al 2002). With such high demand for services, and without a concomitant increase in resources, the risk is that resources may have to be diverted away from other priorities, such as prevention, early intervention and recovery.

## 3. Transforming London's mental health

3.1 London's mental health services have achieved major advances in the last twenty years. Bed numbers have reduced substantially, cost effectiveness has improved, more people are receiving care and support in community settings. London is leading the way in learning about developing home treatment, assertive outreach and early intervention services in urban settings, involving

service users as partners in service delivery and developing effective interventions.

3.2 However, challenges clearly exist. In particular, there are wide variations across London. And London lags behind its international peers in some important areas, particularly in successfully providing services to support employment and training, and enabling people to access sustainable housing options. These are not problems for mental health alone – they are London-wide issues. But their impact for mental health is substantial.

3.3 This paper has identified a range of issues to be addressed. Six key objectives are proposed, with indications of how these objectives are to be achieved:

- **Early intervention;** to promote mental health and provide effective preventative strategies to help those at risk of developing mental health problems, especially severe mental illness
- **A clear pathway of care;** to provide timely access to appropriate services and more consistent pathways through care
- **Promoting recovery and social inclusion;** to improve outcomes and to improve access to evidence-based interventions
- **Local treatment within the community;** to refocus the work of community teams and to reduce dependency on away from home care
- **A new strategy for inpatient care;** to rethink the purpose and improve the quality of inpatient care
- **Working with those at most risk;** to develop effective service models for offenders, to reduce stigma and to improve access in primary care.

3.4 These objectives are underpinned by a number of principles: pre-requisites for change and/or enablers that will facilitate change:

- Getting to grips with and understanding the complete physical and mental health needs of the population as they affect the demand for mental health care across London's communities.
- Taking full account of the impact of both the built environment and the social conditions within which people live when developing new mental health services.
- Changing the nature of our provider partnerships where it makes sense and ensuring a strong joint commissioning approach to include dedicated work on the (new) joint strategic needs assessment.
- Design and develop services in partnership with a range of services and agencies, including primary care, social care, housing services, education, the Criminal Justice Services, voluntary and community services.
- Improve the experience of, and work in partnership with, service users; reduce stigma and encourage involvement from the wider population

- Build in evaluation and research (into costs, quality of care, service design, interventions) and improve data quality
- Learn from other capital cities
- Improve and expand the training of mental health professionals, especially in evidence-based interventions
- Increase resources through more efficient services; better targeting of resources on prevention and stronger evidence-based cases for increased central funding.

# 4. Where action makes most sense

## 4.1 Improve prevention and early engagement

4.1.1 Early intervention (EI) services are aimed at identifying and working effectively with young people with emerging psychotic disorders and their families, and reducing the duration of untreated psychosis. Positive outcomes include reduced bed days, greater engagement with services and fewer admissions involving the police. London is learning about their successful introduction. However, a recent London Development Centre paper reported inconsistent and incomplete data on the number and activity of EI teams in London. London has a younger population profile than the UK and a population at greater socio-economic risk of developing mental health problems; it needs to set the pace and act quickly and decisively to implement effective EI services.

4.1.2 Support and intervention need to start earlier in a child's life and services need to be developed and delivered in partnership with education and schools. For example, community mental health nurses could be based in secondary schools to identify those at risk, provide quick, targeted intervention with young people and families, and help promote mental health and well-being in the wider school population.

4.1.3 Services need to be designed not just for children and young people but for parents and families. For example, routine support with parenting skills should be provided. There needs to be further research on effective interventions to prevent mental health problems in children and young people and on mental health promotion.

4.1.4 Better mental health education of the community is also required, aimed at helping reduce stigma and fear of services, encouraging user and carer contact with services, and helping agencies support mental health service users, for example in open employment.

4.1.5 An early intervention model could also be used to identify mental health conditions in later life, particularly Alzheimer's disease.

## 4.2 Provide more consistent pathways through care

4.2.1 A clear care pathways approach to delivering care, similar to those in other parts of the health system such as cancer care, would facilitate choice, help monitor outcomes, and would enable service users and staff to know what is expected of services, and of service users, at each point in their care.

4.2.2 Access to services needs to be streamlined for routine, urgent and emergency referrals, with consistency across London. The GLA has recommended a single coherent system to enable non-mental health professionals (such as police officers) to refer people for mental health assessment and help.

4.2.3 Managing common, less severe mental heath problems will need to be built into the care pathway approach. Most people do not require secondary mental health treatment but mental health providers need to support GPs to manage care for these people. This will involve working with local authority and local voluntary sector providers who can provide social, employment and housing support, as well as supporting GPs, for example, in the management of medication.

4.2.4 More research is required to help develop evidence-based pathways, tailored to need, that provide appropriate and timely assessment, treatment and support, and then enable service users to move on from the mental health system.

## 4.3 Promote recovery and social inclusion

4.3.1 Mental health services need to work in partnership with a range of statutory and voluntary agencies to promote the recovery and social inclusion of people with mental health problems. This includes developing services that support people into work, housing, social relationships and ordinary daytime activities relevant to their culture, hopes and aspirations. Working with organisations that are not services at all – such as small local businesses and faith communities is also critical.

4.3.2 Working for recovery and inclusion requires a fresh approach to commissioning. It might mean that statutory mental health services act as commissioners of a broader network of support. It will also require wider implementation of direct payments for service users to purchase services they want, a move strongly supported by the London Development Centre and the GLA.

4.3.3 Some aspects of social and economic life, notably housing and employment, need more – and more imaginative – thought and development. Examples of good, evidence-based practice exist, especially in relation to employment and mainly from the United States. But more research is required to understand how initiatives could work in the UK in general and in London in particular. Research and pioneering work around housing and accommodation for people with mental health problems are urgently needed. Mental health services are very reliant here on the structures and incentives of systems outside the NHS.

## 4.4 Improve access to evidence-based interventions

4.4.1 Access to evidence-based interventions to help people with mental health problems needs urgently to be improved. Patients should have the opportunity to choose effective therapy, wherever possible, and to know its expected duration and outcomes. Therapies should be offered in a variety of settings, including primary care, even in specialist high street centres. We are far from this position.

4.4.2 More and better knowledge is now available about a range of interventions to help people with mental health problems. We know, for example, about the effectiveness of cognitive behavioural therapy (CBT) and modern anti-psychotic

medications. We know, too, however, that talking therapies are effective only after proper training and under supervision, and that there are not enough trained therapists to meet demand. There is a pressing need to train therapists and to ensure that there is adequate supervision available within each team.

4.4.3 Generic community mental health teams (as opposed to specialist teams such as assertive outreach or home treatment teams) often have a wide remit but without a clear focus or function. It is timely to reconsider the role and function of CMHTs. This would usefully consider, for example, whether there is room for more specialisation, for example in assessment and/or recovery co-ordination, or in therapies and a wider range of types of support, with the aim of improving the reliability of the CMHT as a service-level intervention. Better data is required in the first instance to identify the composition of CMHT caseloads so that services and interventions can be tailored according to need.

4.4.4 Where highly specialist services are required, such as eating disorders services, networks of specialists could be developed across London, commissioned as such, probably by commissioning consortia.

4.4.5 More research and evaluation continues to be needed into what works for whom, including a range of talking therapies, combined talking therapies and medication, technology and medication-based care.

## 4.5 Re-think inpatient care

4.5.1 There is scope for London to build on alternatives to inpatient care. Targeted community services, with clear functions and the ability to help avoid admission and facilitate early discharge, have been shown to reduce occupied bed days. Focusing services on prevention and in-reach, and developing better community services, as already described, should similarly reduce the need for inpatient care. However, this is a long-term process and a longer-term outcome.

4.5.2 London needs to work on a vision for its inpatient care in which its function and purpose are clearly defined. Hospital could be used as an elective time-limited treatment, for example, to support and monitor the introduction of new medication.

4.5.3 It may be possible to think radically about the configuration of inpatient care across London's boroughs. There is a question about whether inpatient facilities are necessary in each borough in the longer-term, if alternatives are effectively implemented and throughput is delivered more efficiently.

4.5.4 The quality of inpatient care, from the environment through to the therapeutic milieu, needs urgent improvement.

## 4.6 Implement effective service models for offenders

4.6.1 There must be improved funding to take into account the huge demand on London's mental health services if they are successfully to deliver care to offenders, including prisoners with mental health problems.

4.6.2 London's mental health services need to work in partnership with London's prisons to develop pan-London strategies for delivering more effective mental health services to offenders.

4.6.3 Community forensic mental health teams based on assertive community treatment models, and other innovative approaches to working with offenders, could be developed as pathfinders or pilots, to explore effectiveness, cost benefits and sustainability, and the learning shared across London.

## 5. A single outcome for London?

5.1 Identifying just one mental health outcome for London is a challenge. Our aspirations are however clear. We expect all those people living in London to get the maximum out of life, free from discrimination, disability and poverty – 'well being' for all is our outcome.

5.2 For those affected by enduring mental health problems our aspirations are no different and we expect equal opportunity for all.

5.3 For this to be a reality not only must we strive to deliver the best available services when needed but we must ensure the environmental conditions for recovery and the maintenance of health are also in place.

5.4 It is therefore reasonable for us to look at a range of indicators that might help us understand how well we are doing against our single outcome aspiration. Undoubtedly this is a critical issue and developing an outcome framework supported by robust meaningful indicators is important for the whole system.

5.5 Recent technical publications such as the OECD paper; 'Selecting indicators for the quality of mental health care at the systems level in OECD countries' have recommended a set of 12 indicators to cover the four key areas of; treatment, continuity of care, coordination of care, and patient outcomes[1].

5.5 While these provide us with a degree of consensus around the treatment system we also believe it would be worth exploring (with joint commissioners) the following four whole system indicators: -

- **Homes:-** the proportion of people on CPA registers living in a good home defined by a combination of physical structure, the community environment, ownership and/or secure tenancy.
- **Activity:-** the proportion of people maintaining and or returning to meaningful day time activity – paid or unpaid.
- **Inclusion:-** the proportion of people enduring mental health problems self-reporting strong social networks defined by contact time with friends, neighbours and work colleagues.
- **Place of Care:-** the proportion of total packages of care delivered solely in the community resulting in recovery defined by a combination of clinical score and self reports.

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[1] OECD Health Technical Papers NO.17; Selecting indicators for the quality of mental health care at the systems level in OECD countries - Systems level in OECD Countries; Richard Hermann, Soeren Mattke and the members of the OECD Mental Health Care Panel **2004**

**5.6** All of these indicators demand strong partnerships between the NHS and its key partners and therefore require the NHS to revisit the quality of its relationships with others and the way it enters into partnerships in the interest of the people who use its services.

## 6. Summary

6.1 In summary, London has wonderful, diverse, constantly changing communities that nonetheless experiences high levels of deprivation and presents increasing demands on its mental health services. Many innovative services have been developed, and indeed London has led the way in many radical initiatives including early intervention and assertive outreach services. There are centres of excellence of international repute. But there is still too much variability in access to and delivery of care, too much reliance on inpatient care, not enough emphasis on working in partnership with the wider community and a lack of a convincing evidence-base for therapeutic and service-level interventions.

| Summary |
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| ▪ Extending the integrated care approach<br>▪ Promoting mental health alongside physical health<br>▪ Extending choice to all through better care planning<br>▪ Developing further early intervention and prevention<br>▪ Maintaining the majority of care in the community enabling people to remain at home<br>▪ Continuing to move away from acute care but where it is necessary extend the therapeutic model |
| **Table 3** |

6.2 This framework for action sets out core objectives and underlying principles. It is aimed not only at improving what currently exists, but at moving towards a more effective, inclusive vision for mental health in London that helps prevent problems before they start and enables people who have used services to live fulfilling, healthier lives in their capital city.


| Acknowledgement |
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| This Document has been produced by the London Mental Health CEO Group. It is our expectation that it will be refined and developed (over time) in consultation with other key stakeholders. |
| **Table 4** |

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