Modernising mental health services


The King's Fund is an independent charity which promotes good health through policy analysis, development and education in health and social care. Here it describes how the government plans to modernise mental health services.

The government has recently initiated a review of the Mental Health Act, the legal framework which sets out the rights of people with mental illnesses and determines in which circumstances they can be treated without consent. This report looks at the background to mental illness and the changes happening in mental health services.

The term mental illness covers a wide variety of conditions of the mind. In the UK it is estimated that:

- One person in six is affected each week by a neurotic disorder, such as anxiety or depression (Office for National Statistics 1998).
- One person in 250 has a psychotic disorder like schizophrenia, in which they experience delusions and hallucinations that impair thought processes (Nazroo 1997).
- Ten to 25 per cent of the population has some kind of mental health problem, and between 2 and 4 per cent have a serious mental illness (Sainsbury Centre 1998).

Worldwide, 1,500 million people are estimated to have a mental disorder of some kind, accounting for 10.6 per cent of the total burden of illness in the world (WHO 1997). Incidence of mental ill health is rising because of longer life expectancies, urbanisation, war and ethnic violence.

Psychotic conditions are manifested in individuals in periodic crises that can usually be controlled using anti-psychotic drugs. For people with schizophrenia, 25 per cent can be cured permanently - in developing countries, the rate increases to over 50 per cent (WHO 1996).

The causes of mental illness are unclear. A risk of mental illness may to some extent be genetic. Some kinds of illness may be related to difficulties in life such as unemployment, racism, work or school pressures, social isolation, family problems, homelessness or imprisonment. Mental illness is not simply about individuals, but also their environment and the society in which they live.

The diagnosis and treatment of mental illnesses remains a matter of contention. Treatments for mental illnesses include ‘talking’ therapies, such as counselling and psychotherapy, and medical therapies, such as drugs and electroconvulsive therapy (ECT). Care and support programmes involve helping people to manage their lives more effectively, for example in finding a home or a job.

The relative merits and risks of the various therapies are the subject of considerable debate and some disagreement. There is also little agreement on whether ‘personality disorders’ are mental illnesses or not, and whether it is possible to treat them at all.

There are still wide variations in diagnosis and hospital admission rates for different groups of people. African-Caribbean men and women, for example, are between three and 13 times more likely than white people to be diagnosed with schizophrenia, and are also more likely to be treated without consent, and with non-talking therapies (Johnson et al 1997). Globally, low income groups who are culturally and socially distant from health professionals are the most likely to be diagnosed with schizophrenia (WHO 1996).

While mental illness often causes people great difficulty in coping with everyday life, which may lead to self-harm or neglect, people with mental illness are rarely dangerous to others. Yet fears about violence make psychotic illnesses like schizophrenia the focus of much public concern. They receive large amounts of media coverage resulting from isolated incidents of violence, even though there is little evidence that people with most mental illnesses are more likely to behave violently than anyone else (Heginbotham 1998). A recent study from the Institute of Psychiatry found that the proportion of all killings committed by people with mental illnesses has fallen from over 40 per cent in the early 1960s to about 10 per cent in the mid-1990s (Taylor and Gunn 1999).

The stigma that attaches to all kinds of people with mental illness may actually make matters worse by leading to isolation, unemployment and educational under-attainment. Public opposition to the location of community mental health facilities is also commonplace, often fuelled by a lack of information and inaccurate suggestions from local media and politicians (Mind 1997).

It has been government policy since the 1970s to provide care in the community for people needing specialist help who do not need to stay in long-term institutions (DoH 1975). Since 1990, the policy of community care has aimed to enable people with mental...
illnesses and other long-term conditions to live independent and dignified lives at home (DoH 1990). These policies have resulted in the closure of many Victorian psychiatric wards and the creation of new community-based services. The number of hospital mental health beds has fallen from 150,000 in the 1950s to 40,000 in the 1990s (Hegnbootham 1998). However, there has been a significant rise in the number of beds in hostels, supported housing and similar schemes.

For many thousands of people, community care has provided an opportunity to live fulfilling lives outside restrictive institutions. When implemented properly, it puts the quality of life of the user at the centre of care planning. Most people with mental illnesses need effective treatment, decent housing, sufficient incomes and worthwhile activities in which to participate.

A lack of resources and poor co-ordination have, however, weakened the effectiveness of community care in some parts of the country and created widespread public mistrust. Some individuals have received insufficient or inappropriate care because psychiatrists, nurses and social workers have not worked together properly, or because the places they felt were vatrial were not available in the services required. Many NHS trusts experience difficulties recruiting and retaining mental health professionals. Last year, for instance, 13 per cent of consultant psychiatric posts were vacant (Sainsbury Centre 1999). The carers of people with mental illnesses have also found it hard to gain access to the support they need.

The government has announced a new £700 million strategy for mental health services (DoH 1998). It aims to give people with mental health problems access to a full range of ‘safe, sound and supportive’ services to help them to live in their own communities. The strategy includes:

■ Better assessment procedures to determine the needs of people with mental health problems and the likely needs of local populations.

■ A network of ‘assertive outreach’ teams of health professionals. Last year, for instance, 13 per cent of consultant psychiatric posts were vacant (Sainsbury Centre 1999). The carers of people with mental illnesses have also found it hard to gain access to the support they need.

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■ Better access to services which respond to changes in their conditions. They need a high level of care during periodic crises and the chance to lead ordinary lives at other times. The estimated 15,000 people with severe conditions who cannot, or will not, keep in contact with services need the most active support. They should be enabled to live normal lives for as much time as possible, but given appropriate care as soon as it is necessary and be monitored regularly by assertive outreach teams (Sainsbury Centre 1998).

■ A responsive and comprehensive service requires not just specialist teams but a major role for primary care. As the most accessible part of the NHS for most people, GP surgeries should be the main point of contact for the majority of those with mental illnesses who do not have complex needs.

■ The challenge for the future of mental health care is to provide treatments and services which are flexible and accessible enough to meet the changing needs of users and carers in their own environments. They must aim to foster the inclusion of people in their communities rather than perpetuating their isolation.

■ The government has stated that community care has ‘failed’ and it has pledged to make public safety a priority in mental health services. Its review of the Mental Health Act may lead to the creation of community treatment orders, which would require patients to undergo the treatments prescribed for them outside psychiatric hospitals and without consent.

■ There are concerns that such an approach is based on well-publicised concerns about violence by psychiatric patients and will unfairly restrict many people’s freedoms. An emphasis on dealing with the small number of very difficult people will also appear to confirm myths about the risk all those with mental illnesses pose to public safety, by suggesting that they can only live safely if they are coerced and controlled (Hegnbootham 1998).

■ Most people with serious mental illnesses, or their carers, say they know in advance when they are going to suffer crises. It may therefore be more appropriate to develop systems which are responsive rather than restrictive.

■ A balance will need to be found between the rights and responsibilities of both patients and the public. Users should be able to participate in treatment decisions to ensure they match their needs, after which they should have a responsibility to comply with negotiated treatments. Ensuring public safety should be the end result of a service dedicated to finding the most appropriate care for everyone who needs it, not the main purpose of a system designed to constrain people’s lives.

■ The public need better information about mental illness to dispel many of the myths that surround it. They also need to see services that treat patients as responsible citizens who can live safely without requiring constant control. This is essential to tackle the isolation and discrimination that exacerbate the problems of people with mental illnesses.

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