Mental health

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The green paper *The Health of the Nation*¹ presents an opportunity to forge a practical and ambitious strategy for the development of English mental health services into the twenty first century. Its structure encourages clarity of purpose, specificity of interventions, and accuracy in measuring outcomes of treatment, and this we applaud. We do not, however, agree that "it is unrealistic to set health outcome targets for these services." Indeed, it is through setting targets that we may now promote the central place of mental health in a healthy nation.

Historically mental health issues have been marginalised within medical practice. Two recent examples illustrate this point. The World Health Organisation's programme Health for All by the year 2000 includes only one mental health goal within the 38 areas—to reduce suicide rates.² Similarly, only 13 of 133 English districts recently surveyed mentioned mental health matters in their 1989 public health reports.³ This neglect is unwarranted. Mental health planners and practitioners already have tools to measure the success of much of their work.^{4,5} The onus should be on psychiatrists at the local level to pursue active collaboration with public health doctors to identify local needs and to plan services.

In our view, however, mental health targets should extend beyond mental illness services, and should include the domains of prevention, promotion, and the psychosocial aspects of general health care.⁶ These last three domains have been underemphasised in the NHS, and contributions are needed from colleagues across a wide spectrum of interests to join debate on these aspects of mental health policy. In this article we shall focus on the psychiatric treatment and care of adults, accepting that parallel initiatives are needed in related fields, including the mental health of children, families, and elderly people.

Why should mental health be a key area?

The green paper requires key areas to be justified in terms of the burdens of mortality, morbidity, and cost. Although death is not often seen as an adverse outcome of mental illness, the all cause mortality for schizophrenia, for example, is estimated to be over twice that of the general population,⁷ principally attributable to suicide, accidents, and cardiovascular disorders. The

extent of psychiatric illness in the population is sobering.^{8,9} Surveys in primary care have shown that at least 26% of the population consult their family doctor each year with a mental health problem.¹⁰ In addition, there is considerable illness among patients' relatives and care givers, who often develop psychiatric symptoms from their burden of care.¹¹

The costs of mental ill health are also staggering: these problems account for 14% of days lost to work, 20% of total NHS expenditure, 23% of inpatient costs, and 25% of pharmaceutical charges.¹ The total annual costs of mental illness are estimated at £4.6-£5.6 billion,^{12,13} less than a third of which is for direct services. Mental illness, therefore, amply fulfils the three criteria necessary to qualify as a key area.

What should mental health targets be?

We support the overall objective of the green paper "to reduce the level of disability caused by mental illness by improving significantly the treatment and care of mentally disordered people," but we want services that are local and accessible, comprehensive, flexible, culturally and ethnically appropriate, accountable, equitably distributed, and based on need and that offer continuity of treatment and care.^{14,15}

The government's single target is "To realign the resources currently spent on specialist psychiatric services into district based services, thereby allowing many of the remaining 90 psychiatric hospitals... to be closed."¹ We believe that this target needs amplifying and propose that mental health targets be set at five levels of intervention; responsibilities should be defined at national, regional, district health authority or family health services authority, provider, and patient levels. Tables I-V detail our proposed targets for each level. The targets and their indicators are intended to stimulate debate between health and social agencies, service users, and the voluntary sector so that ambitious and detailed targets for mental health can be incorporated into the white paper.

The targets cover structure, process, and outcome. In terms of structure of service a consensus has emerged over the past decade on the characteristics that locally based services should assume.^{16,17} Regions and districts should first make an inventory of the range, character, and size of local facilities and then

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TABLE I—National targets and indicators for mental health

Target	Indicators
Develop measures of progress toward national mental health objectives	<ol style="list-style-type: none"> 1 Develop standard national descriptions of mental health service components by 1 January 1993 2 Publish an annual national mental health report from 1 January 1993 including (a) the number and rank order of day, residential, inpatient, day patient, outpatient, and home care facilities in each district and (b) the number of patients detained under the Mental Health Act
Continue hospital rundown programme	<ol style="list-style-type: none"> 1 45 Of the hospitals now with over 400 beds to close by 2000 2 No psychiatric hospital to have over 400 beds by 1995 and none over 250 beds by 2000. 3 Specific transitional funding arrangements to be provided by Department of Health to regions 4 The proportion of mental health expenditure on local facilities to increase by 40% by 1995 and by 60% by 2000
Reduce preventable deaths	<ol style="list-style-type: none"> 1 Reduce the number of former patients committing suicide by 10% by 2000. 2 Reduce standardised mortality ratio among schizophrenic patients by 10% by 2000 3 Provide health education on smoking to 50% of psychiatric patients by 1995 and to 90% by 2000 4 Increase the proportion of psychiatric units operating no smoking policies to 50% by 1995 and 90% by 2000
Structural requirements	<ol style="list-style-type: none"> 1 Establish long term and serious mental illness as the national priority group for mental illness services 2 Establish ringfenced health and social services budgets by 1 April 1993 3 Establish clear mental health definitions—for example, for long term and serious mental illness 4 Convene a national mental health commission by 1 January 1993 to oversee annual mental health report 5 Establish a national mental health resources centre by 1 October 1993

TABLE II—Regional targets and indicators for mental health

Target	Indicator
Develop measures of progress toward regional mental health objectives	1 Annual regional mental health report with common core information 2 Increase proportion of community to hospital expenditure by 40% by 1995
Continue hospital rundown programme	1 45 Of the hospitals now with over 400 beds to close by 2000 2 No psychiatric hospital to have over 400 beds by 1995 and none over 250 beds by 2000 3 The proportion of mental health expenditure on local facilities to increase by 40% by 1995 and by 60% by 2000
Structural requirements	1 Ringfenced regional mental health budgets 2 Establish local manpower requirements

TABLE III—Mental health targets and indicators for district health authorities and family health services authorities

Target	Indicator
Develop measures of progress toward district mental health objectives	1 Annual district public health report by 1 October 1992 with common core information
Develop locally based services	1 Over 90% of catchment area patients treated in district health authority by 1995, over 95% by 2000 2 Increase proportion of community expenditure by 40% by 1995 and by 60% by 2000 3 Set minimum requirements for provision of day care places by 1 October 1992 4 Set minimum requirements for sheltered residential places by 1 October 1992 (for example, 100 places/100 000 population as in Cambridge) 5 Increase proportion of community to hospital staff by 40% by 1995 and 60% by 2000 6 Reduce number of inpatients with psychosis who have been in hospital for over 6 months and 1 year by 20% by 1995 and 40% by 2000 7 Set target proportion of former patients with psychosis in contact with services and on local case register at 75% by 1995. 8 Set target proportion of mentally abnormal offenders who are treated in district services by 1995. Set maximum waiting times for mentally abnormal offenders in special hospitals and at regional secure units to return to district facilities 9 Increase number of community mental health teams in each district 10 Increase number of community psychiatric nurses who have received training in working with long term patients 11 Reduce number of days by which 50%, 75%, and 90% of patients had been discharged
Structural requirements	1 Ringfenced budgets 2 Establish joint local mental health strategic plans 3 Ensure user representation at local planning level by 1 January 1992 4 Complete needs assessments on over 90% of patients in target groups (for example, homeless mentally ill) by 1 April 1993
Develop liaison between primary and secondary care levels	1 Increase proportion of psychiatrists working in primary care settings by 20% by 1995 2 Continuing training for over 20% of general practitioners in the treatment of serious mental illnesses by 1 October 1993

TABLE IV—Mental health targets and indicators for providers

Target	Indicators
Structural requirements	1 Relevant discharge and care programme plans completed for 90% of patients with psychosis and organic mental disorder by 1995 2 Establish local information systems of vulnerable patients by 1 January 1993
Service characteristics	1 Managed multidisciplinary community care and hospital teams in each unit by 1 April 1993 2 Clear written local service objectives with rank of priorities by each unit by 1 April 1992 3 Increase proportion of face to face interagency contact by 10% by 1 January 1993 4 Decrease proportion of patients with joint care plans who have not contacted service in past 6 months 5 Increase proportion of long term patients in sheltered work or day care facilities 6 Increase the proportion of patients receiving depot antipsychotic drugs who have a care programme with regular multidisciplinary reviews 7 Less than 5% of acute beds occupied by patients staying over 60 days 8 Less than 10% of discharge patients readmitted within 6 months

draw up a timescale during which services should be reoriented towards specific targets. The evidence suggests that the worst of service provision is very poor. Most districts, for example, have no mental health respite care facilities.¹⁸

Process variables, although underemphasised in the green paper, may be crucial in tracking the function of services. Evidence from mental health centres, for example, suggests that policy targets will not be met unless the process of care is strictly monitored.¹⁹ But perhaps the single most important change in process variables is to increase the proportion of the £1.5 billion NHS mental health budget that is spent on local mental health services. At present over half is spent on the 40 000 psychiatric patients remaining in hospital. If we conservatively estimate that about 180 000 (0.5%) of the 36 million adult population of England²⁰ suffer from severe forms of mental illness^{21 22} then less than half the total expenditure reaches the 78% of severely disabled patients who live in the community.

Validated outcome variables are available for only some of the domains that require measurement (see table V), and investment is urgently needed in the construction and testing of further measures.^{23 24} This task may fall within the remit of the new research and development division of the Department of Health and will allow brief and standardised measures to be disseminated to the local level. Methods have been established for measuring severity of symptoms, social behaviour, cognitive function, social role performance, needs assessment, and social networks.

Further development is needed for measures of user knowledge and satisfaction and carer burden and for brief cost effectiveness rating scales.

What should the strategy be?

Nationally two prime structural issues must be addressed. Firstly, there is a lack of leadership, with no identified organisation taking responsibility for policy development and implementation. Instead policy is decided by a plurality of organisations with un-coordinated inputs including the Audit Commission, the Mental Health Act Commission, the Department of Health, the Royal College of Psychiatrists, and the Health Advisory Service.

Secondly, within government there is no formal mechanism for interdepartmental coordination of mental health policy. It has long been clear that social factors, which cut across usual departmental bound-

TABLE V—Mental health targets and indicators for patients

Target	Indicators
Measure clinical disability outcomes	1 Self rated symptom scales 2 Interviewer administered symptoms scales
Measure social disability outcomes	1 Employment 2 Social roles 3 Social behaviour
Measure user assessments of services	1 Satisfaction with care 2 Knowledge about services 3 Relatives burden rating 4 Quality of life measure

daries, have a key role in psychiatric morbidity.²⁵⁻²⁷ Unemployment, for example, often produces an unacceptable level of anxiety, depression, self harm, and suicide.²⁸ The green paper officially recognises these health variations and proposes a pragmatic strategy that would formally integrate health and social policy. Such a ministerial grouping would necessarily include the Departments of Health, Social Security, and the Environment. An alternative strategy would be to set up a national mental health commission.

In either case the priorities would be to develop clear policies on provision of mental health service, to review the functions of the diverse organisations, to recommend how the organisations could be focused and coordinated more effectively, and to agree national standard definitions—for example, of serious mental illness, new long term patients, and types of residential care. A further priority should be to establish a national mental health resource centre to plan and implement community services and produce sophisticated and effective protocols to guide service developments, along the lines of the recent Social Services Inspectorate report on children and adolescent homes.²⁹

There is a strong case for having regional task forces to support providers in auditing current practice and in preparing checklists against which local services can be appraised. The task forces could help local services look more systematically at process and outcome, set targets, and advise on management and service structures. Progress should be recorded according to a standard format in each annual regional public health report.

Another area of concern is the lack of provision for transitional service developments at each level of ringfenced, time limited funding. Provision needs to be made according to clearly formulated and rational guidelines. An example of poor practice is the recent introduction of the mental illness grant to social services departments; the lack of clarity and the inadequate time allowed for planning has led, in many instances, to cosmetic rather than radical innovations with little indication of outcomes.³⁰

At district level one of the most fundamental barriers to rational planning and evaluation has been the lack of even basic infrastructures for obtaining information.^{31 32} Strategic guidance from both regional and national levels has been minimal, and while local ownership of such systems is crucial to their success, the provision of expert consultants could expedite the development of systems more relevant to planning than the current performance indicators.

Locally purchasers may increasingly wish to use service specifications to insist on agreed priority groups of patients; measures of structure, process, and outcome; annual district public health reports including mental illness indicators in a standard format that allows direct comparisons across units; and providers actively pursuing close liaison between primary and secondary care services.³³

These proposals go far beyond the single target set for mental health services in the green paper. They require a commitment at each level to accord mental health and mental illness services a priority never previously enjoyed. They raise the possibility that the

Cinderella services may not necessarily return to dreary rags after the glitter of the green paper ball.

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Correction

Missing: a strategy for health of the nation

This article by the Radical Statistics Health Group (3 August, p 299) was wrongly attributed to Allyson Pollock on the cover. The article expresses the collective views of members of the group. In addition, two editorial errors occurred. The third paragraph of the section entitled "A strategy for health?" should have said that road traffic accidents caused 4938 deaths in 1985, not 938. The first sentence of the fifth paragraph in the same section should have stated that the incidence of asthma may be rising, not is rising.