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MENTAL HEALTH IN THE NHS: A SUITABLE CASE FOR TREATMENT?

Not long ago a young man with a diagnosis of paranoid schizophrenia was convicted of the manslaughter of another young man, Richard Whelan, while he was on his way home with his girlfriend on the N43 bus in North London. His name, Anthony Joseph, was by a chilling coincidence the same as that of the hostel resident who killed my colleague, social worker Jenny Morrison, 10 years ago by stabbing her 127 times.

We know that about one person a week is killed by someone with a mental illness, a rate that has stayed the same for the past 50 years and is equivalent to between 5 and 10% of the 600 or so homicides committed each year in the UK. We also know that the vast majority of people with a mental illness who commit serious crimes do so because their illness has not been adequately treated. So what has happened to mental health services in the years since Jenny died?

Spending on mental health has certainly gone up steeply over recent years – by 31% in real terms from 2001-2 to an impressive £5.2 billion in 2006-7. This accounts for 12% of the total budget for the NHS which now employs 1.3m people. This extra cash, as always, has come from the taxpayer. A recent Grant Thornton study shows that a £100k a year household can lose up to 53% of its income in tax while a single person earning half that amount stands to lose perhaps as much as 56%. In fact, under New Labour tax revenue as a proportion of GDP is now a staggering 37.4% as compared with 35.3% in 1975 when Old Labour was at its peak.

According to the Sainsbury Centre for Mental Health - which is independent of government so its voice must carry some weight – we are still not spending nearly enough. It tells us that cash for mental health must increase by 50% in real terms and that 30,000 (sic) more staff are needed by 2010-11. As tends to happen when more spending – and therefore more taxation – is being called for, it calculates that the cost to the UK economy of mental ill health is somewhere in the region of £77 billion, which includes £41 billion for "reduced quality of life and loss of life".

So the picture seems fairly clear. We are paying a lot more in tax and this money is directed towards the relief of the undeniable suffering that mental ill health brings. This at least is how the government sees it. In November 2006 Lord Warner told Parliament during the second reading of the Mental Health Bill towards the end of its long and expensive gestation: "let me be clear about improvements we have put in place on mental health services. We are spending £1.5 billion more on [these] services than in 1999. At £7.2 billion mental health represents the largest single element of programmed budget spend in the NHS".

Good government and noble sentiments you might think – but this statement contains a non-sequitur so fundamental that it is paradoxically easy to miss. It is that more spending equals better services. Professor Louis Appleby, the Sanity Tsar, or National Director of Mental Health as he is formally known, is clearly in step with his employers. He tells us that over the past few years 713 new specialist mental health teams have been created – this at a total cost of £0.3 billion. They are teams responsible for so-called Crisis Resolution, Early Intervention and Assertive Outreach, the latter an import from the US where local mental health services are far less developed than in the UK. Between them these three services were in contact with over 130,000 patients.

A progressive service producing impressive figures, it would seem. But in fact there is little or no evidence that having separate specialist teams, as distinct from a basic, generic service, produces any extra therapeutic benefit at all. In two major studies Assertive Outreach teams did no better than generic teams and in one of these the patients of a generic team in the control group actually spent less time in hospital than those of the specialist team. And with caseloads in the specialist services being about a third of those in traditional ones, these findings are worse than they first appear.

This is in no way an attack on the staff in these new teams, most of whom are hard-working and committed, but

it does reveal a fallacy in government thinking about mental health – that distinct functions, say, responding in a crisis or early in someone's mental health career, must be provided by separate services. This is a concept which has migrated over from physical medicine where the body is increasingly divided up into smaller and smaller parts, and allocated to discrete micro-specialisms. This doesn't work in psychiatry because the mind – thinking – is a single entity. Dependence, say, on alcohol will be connected with anxiety, with personality, with mood and family dynamics, and so on, yet someone struggling with all these problems might see three, four or even more professionals in a few months.

To an outsider, the voter or taxpayer perhaps, familiar with the re-packaging and the re-branding of the marketplace, this may seem a relatively trivial matter but, unlike the market, it consumes vast amounts of our taxes. More important for those who struggle with mental illness and for their carers, the simple but comprehensive mental health system which was set up in the early 1990's to deal with the fragmented service we had for so many years is now being undermined by a different kind of fragmentation. This is largely a function of this government's susceptibility to fashion and vested interests or gurus promoting the latest bright idea or initiative, which militates directly against the essential components of an effective mental health service – stability, consistency and continuity.

An unintended consequence of this new fragmentation of services for the mentally ill is that since the death of my colleague risk has, if anything, actually increased because patients with serious and potentially dangerous conditions may often be looked after by two or three specialist services simultaneously or have their care and supervision shifted from team to team. The result is that no individual professional gets to know them in the round and build up a composite picture of how they think and function, and of the risk they may pose. I have studied over 60 homicide inquiry reports and in none of them was a shortage of resources or staff a relevant factor. On the contrary, most patients who went on to commit homicide were known to a dispersed range of professionals working in a complicated patchwork of different clinical teams.

This was true even in the case of John Barrett, who was allowed ground leave from his secure unit in South London in September 2004 but went to Richmond Park where he killed Dennis Finnegan as he cycled through. Different aspects of Barrett's mental state and connected problems were allocated to several different professionals with the result that no-one got to know him well enough to engage him properly and form a penetrating view of the risk that he self-evidently posed.

Well at least our taxes have gone into direct clinical services even if they may have been organised unwisely, you might think. If only this were so. In 2005 the government created a body called the Care Services Improvement Partnership (CSIP), which will mean little if anything to most clinical staff on the ground. It costs over £35m a year and, among other things, manages or funds 31 different websites. It is also responsible for the National Institute for Mental Health in England, which has 8 "development centres", 31 different "leads" overseeing topics from gender to stigma, and "knowledge management" to "international initiatives", all of them estimable in their own right, of course. In addition to these, there are 8 "National Leads" responsible for, among other things, "Integrated Care Networks" and "Tele-care and Housing Learning and Improvement Networks".

In conjunction with the "Valuing Support Team", CSIP has just finished its "Autumn Assessment" exercise for mental health services which "sets out to relay progress on the implementation of the Mental Health National Service Framework along with the Combined Mapping Exercise, the Themed Review and the Self Assessment" (sic). For good measure, it is at the same time promoting something called the "Primary Care Trailblazer".

Other mental health players on the Department of Health's books include the NHS Modernisation Agency (with a "Community of Workforce Managers"), the NHS Institute of Innovation and Improvement, a Health and Social Care Change Agent Team, the Commission for Patient and Public Involvement in Health, the National Patient Safety

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Agency and the Social Care Institute for Excellence, responsible for an impressive total of 120 publications since its inception in 2002. There is also the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection – but at least they are going to merge later this year!

Would that the list of bodies which are not providing any kind of direct clinical service ended there. Other DoH initiatives include the National Service Framework for Mental Health, which has produced 101 "guidance documents" for staff , 40 "Community Engagement Projects", an "Improving Working Lives Practice Plus National Audit Instrument", 17 "Programmes for Change", a "Pacesetters Programme" and the current bible for Mental Health Trusts and their paymasters, Primary Care Trusts(PCT's) – "Payment by Results" (PbR). This has in turned generated a "Mental Health Payment by Results Care Pathways and Packages Project" where you will find "indicative unbridled tariffs" and "updated groupers for road-testing" (sic). It goes on and on: the "Strategic Learning and Research Group for Health and Social Care", the "Council for Healthcare Regulatory Excellence", "Health Gateway Project Review Teams" and more.

Most clinical staff in direct contact with patients sensibly tend to keep their heads down and their focus on the care and treatment they are doing their best to provide – in the hope that this hurricane of policies and initiatives will simply blow over. If only. There is huge cost involved in these excesses, not just in cash and in time but in energy and thinking as well, with the attention of middle and senior managers being taken away from a focus on the care of the patient to the extent that the bureaucratic imperative has almost entirely annexed the therapeutic one.

Mental health services are now commissioned, to use the technical word most clinical staff simply don't understand, by PCT's – an arrangement which goes back to the so-called purchaser-provider split devised by Sir Roy Griffiths in his ill-fated review of health and social care back in 1983. This means that Trusts have to provide a fantastic array of statistics which everyone who has a real interest in patient care knows have no bearing whatever on the quality of the service they struggle against the odds to give to the mentally ill.

Mental health teams in one average Inner London borough now have to produce 115 different "performance indicators" every single quarter. And bear in mind that most of these have to be generated by busy clinical staff who are now chained to voracious IT systems and increasingly reliant on underpaid admin staff who leave for the private sector as soon as they can. Walking into a clinical team room is like straying into the typing-pool since the introduction of RiO, a new all-London computer system. Consultant psychiatrists now function like secretaries much of the time, forced to gather over 60 bits of information from patients on their first appointment and then obliged to fill in the 40 or so electronic forms that RiO demands. All of this makes clinical staff not just physically unavailable to patients but – and this is the real tragedy – much less psychologically available to them because both their attention and morale are sapped by the need to keep feeding the machine.

In the mental health arm of the NHS we now measure everything except whether the patient is getting better. And, believe it or not, clinical staff are now being trained in the "overarching vision" of something called the "Recovery Model" which says they must actually abandon the concept of "getting better". Instead of treating the symptoms of mental illness - which is what most sufferers and almost all carers actually want - staff are told they must instead address society's major challenges, such as social exclusion, discrimination and power relationships. What used to be a service for people who are ill must now provide motherhood and apple-pie instead.

This "Model" has nine headings which include "power and control" and "peer support and relationships" – important concepts, of course – but these are further divided into three different "levels", all of which is repeated four times for four different "stages", resulting in 552 bullet-points for clinical staff to digest and apply on the dwindling number of occasions when they actually get to see a patient.

If you add in the 39 different kinds of mandatory training that mental health staff are obliged to attend, the

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blizzard of directives from the National Institute for Clinical Excellence and bodies such as the National Treatment Agency for Substance Misuse (118 employees and a budget of £11m), whose recent review of services for alcohol dependence ran to 212 pages and listed eight different "screening tools" and no less than ten different forms of treatment, is it surprising that the morale of many clinical staff is in meltdown? Not only does all this stuff undermine their confidence and self-esteem, it also takes them away from what they were trained to do and feel passionate about – caring for and improving the health of the mentally ill.

So is the NHS a sleek and progressive organisation which is finally investing serious money in a service which has been neglected and under-funded – or a megalithic machine which rumbles on, its momentum flattening obstacles – and objections – in its path because no-one remembered to give it a brake? Well, of course, it depends who you ask. And this is because mental health NHS Trusts have in effect become two separate organisations. There is now a dominant managerial class, well removed from the patient, who believe they are running a business. This "business" is not subject to the discipline of the market; it is in fact a local monopoly. The second group is a subordinate clinical class who feel persecuted, undervalued and, in a strange way, almost irrelevant.

These two classes do, however, have one thing in common – feelings of impotence which occasionally even approach hopelessness. That is, senior managers believe there is nothing they can do to halt the Department of Health juggernaut while clinicians feel the nature of the job which used to inspire them – caring for and restoring to health the mentally ill - has changed forever.

Mental health services in the NHS have become a suitable case for treatment and are now in need of radical cultural change. This can only be provided by government. Careerism must no longer be rewarded at the expense of vocation. In practice, the most experienced and able staff should have the most contact with patients - not the least, as is now the case. Secondly, clinical staff, in partnership with patients and carers, should be at the apex of a streamlined structure which supports and facilitates their work rather than at the bottom of a growing hierarchy which devalues and oppresses them. They should be freed from the absurd and counterproductive administrative demands which every new initiative and protocol generates.

Prescriptive control from the centre does not create a safer and more effective mental health service. Instead, at vast expense, it saps motivation and morale. This is the sad, stark lesson from the ten years since Jenny Morrison died.

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