

Breaking down barriers

*Clinical Case for Change: Report by
Louis Appleby, National Director for Mental Health*



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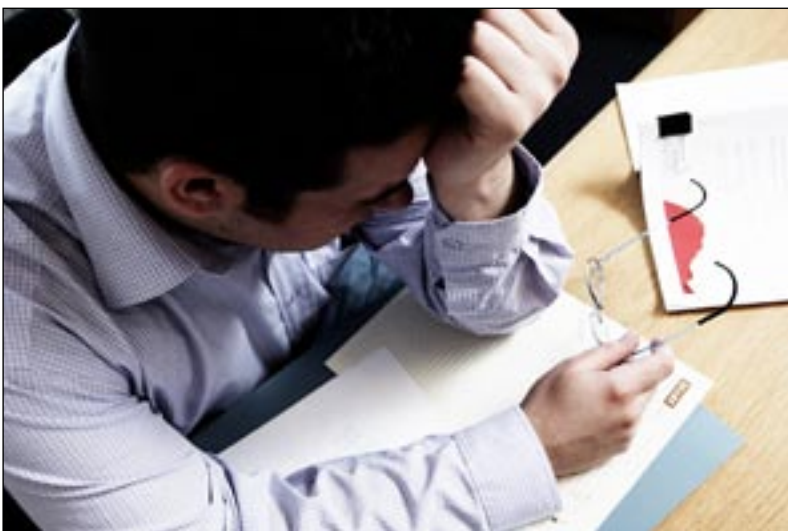
Breaking down barriers

Introduction

Employment, housing and a strong social network are as important to a person's mental health as the treatment they receive. Louis Appleby, the National Director for Mental Health, explains why we have to continue to improve community care and break down the barriers that can prevent people from rebuilding their lives.

Many people do not realise the extent of mental illness or the impact it has on the individual, society and the economy.

The figures speak for themselves. At any given time nearly a sixth of all adults are experiencing depression or anxiety. Mental illness accounts for a third of all illness in Britain. More than 1.3m older people have a mental illness such as depression and this figure will rise as the age of the population increases.



The total cost to the nation of mental ill-health is as high as £77bn¹ each year in lost earnings, productivity and reduced quality of life.

But the true cost to a person's life is almost incalculable. Unemployment, homelessness and destroyed relationships are just some of the potential

consequences of mental illness. Even those of us who work in health and social services can underestimate how wide the impact of mental illness can be – the extent of the patient's anguish, the distress of carers and the barriers to seeking treatment.

A Short (and Personal) History of Community Care

My first job in mental health was as a nursing assistant in a large long-stay asylum. It was the summer 1973, and I was between school and medical school. The patients on my ward were

¹ Sainsbury Centre for Mental Health: "The total cost of care is estimated to be over £12 billion. A further £23 billion is lost, as many people diagnosed with a mental health problem are unable to work. Reduced quality of life and loss of life may account for over £41 billion every year."

mainly people with severe mental illnesses such as schizophrenia and they had been there for years. Their treatment consisted of anti-psychotic drugs that had seemed pioneering when first developed in the 1950s but which caused unpleasant side-effects – restlessness and involuntary movements of the face muscles. The staff were kind and concerned, but there was no sense that we were preparing people for recovery or for life outside hospital. Part of my job was to hand out cigarettes.

Mental Health in Numbers

1. Costs the nation £77bn a year.
2. One sixth of the population suffers from a mental health problem every day.
3. One million people on incapacity benefit suffer mental health problems.
4. 12% of the NHS budget is spent on mental health.
5. Mental health accounts for 1/3rd of all illness and 40% of all disability in Britain.
6. More than 1.3m older people suffer from depression or other mental illness.
7. One in ten mothers suffers from post-natal depression.
8. Since 1997 the number of consultant psychiatrists has risen by 55% (2,447 to 3,800).
9. Since 1997 the number of psychologists has risen by 69% (4,100 to 6,800)
10. Since 1997 the number of psychiatric nurses has risen by 9,300 (39,109 to 48,400).

By the time I began training as a psychiatrist in 1983, the move to community care was well under way. Many long-stay beds had closed. It was known by then that patients would fare better in a more stimulating setting than most long-stay wards could offer. Mental hospitals were seen as out-dated and unhelpful to recovery, while treatment in the community could prevent patients from becoming institutionalised. And crucially, there was a widespread belief that institutional care was expensive and that community care would be cheaper.

Throughout the 1980s and 1990s I worked in a system struggling to make community care a success. The old long-stay patients needed somewhere to live and something to do – otherwise the community would become as under-stimulating as the hospitals they had left. For many people, the right facilities simply weren't there.

By now the move to the community was not only about long-stay wards. Community care was increasingly seen as an alternative to hospital admission for shorter periods of illness as well. People who would once have been offered a hospital bed for a few weeks to help them get over a relapse might now be treated by community teams. The problem was that the services were not well-developed – the “team” I worked in consisted of a social worker, a nurse and me.

At the same time, there were changes in the problems that we were dealing with – more drugs, sometimes violence, growing public expectations and a media spotlight that sought out the tragic cases when things went wrong. We seemed to be facing more volatile illnesses and greater risk. The use of the Mental Health Act – one measure of the pressure on services – rose year on year.

By the late 1990s the prevailing view was that community care had failed.

Community Care – Making It Work

All this has changed, as illustrated by the story of Lisa, a mother from the West Midlands.

Lisa has a severe mental illness and when it flares up she needs additional care which in the past has meant admission to hospital. Recently she was given the choice between hospital care and treatment at home for the first time in her life and this is what she said about it:

“I wasn’t feeling very good. I kept crying a lot and I was very sad and miserable.

My daughter said to me: “Mummy, do you know all I want for my birthday? I want you to be happy.”

I couldn’t go to the doctor, I just sobbed. I said: “They are going to put me in hospital and I am not going to see Ellese on her birthday.”

That’s what I wanted. I wanted Ellese to see me smiling on her birthday. I said to the doctor, “Please don’t put me in hospital.” He said, “I would have asked you to come into hospital. However, there are home treatments available and because I can see how you are feeling I am going to suggest that they come and assess you.”

That’s how I came to have the Home Treatment and it’s benefited me more than anytime I’ve had on a ward.”



Thousands of people like Lisa were treated at home last year instead of going to hospital. We no longer rely on beds to help people with serious difficulties – and patients are given care that they prefer by specialist teams.

New Approaches to Mental Health

1. Care closer to home
2. Earlier intervention
3. 24/7 home treatment
4. Tailored care
5. Better access to modern drugs
6. Multi-disciplinary teams
7. Talking therapies

Mental health care reform entered a new phase in 1999 with the publication of a policy blueprint, the National Service Framework. The following year, a series of new clinical services was launched in the NHS Plan. The over-riding aim was to solve the problems of community care: to ensure that patients received effective modern services and, as a result, to restore professional and public confidence in a system of care that was vital to the lives of so many people.

Eight years on, it is no exaggeration to say that this has been a period of unprecedented transformation. Large increases in funding and in numbers of staff have created the essential foundation for changing the way that care is delivered.

We now have more than 700 specialised mental health teams across 60 mental health trusts. These include:

- 252 assertive outreach teams – intensive community support for patients who might not otherwise accept treatment or attend appointments
- 343 crisis resolution teams – for people who can safely be treated at home but who need access to close support
- 118 early intervention teams – a quick response for the 7,500 young people a year who suffer their first episode of psychosis

These new teams mean we can identify and address problems earlier, provide home treatment as an alternative to hospital and engage patients who do not respond to traditional care. They are staffed by a range of professionals, so that patients get the best of nursing, clinical psychology and social care. The teams work closely with in-patient units. There are benefits to patient care, as well as to the job satisfaction of staff. Also, admissions under the Mental Health Act have not risen since 1999.

An early intervention team in Worcester is helping Anthony, 24, regain his confidence enough to return to university in September.

“I was at university and I just started seeing an alternate world,” Anthony explained. A consultant diagnosed Anthony as suffering from psychosis and referred him to the early intervention team.

“They are a really tight bunch of people, and I’m sure if I wasn’t with them I wouldn’t be making as much progress.”

His care plan included drugs, psychiatric sessions and compiling a diary with a mental health nurse at home. Half way through his three year treatment, he now just meets his nurse once a week in Worcester town centre to have a coffee and a chat.

Anthony said: *“The diary sounds superficial but it was important because it gave me an indication of how well I was doing. It puts your mind at rest. Now I just have a chat once a week about any problems I’ve had.”*

His father Andrew has appreciated the service almost as much as his son. He said: *“It’s a shock when you’re told you son has a problem. The reassurance that it is being managed in a structured way gives you confidence that things will improve. I don’t think he would have progressed without the team’s focus and structure. It’s almost run like a business with milestones and six-monthly reviews which everyone is involved in.”*

Andrew added: *“It has also helped the family to cope better. We feel part of the team and feel included in Anthony’s recovery.”*

The next phase of reform – removing barriers

Much of the progress of the last few years has been in specialist mental health services – that, after all, is where the most obvious problems were. The task ahead of us now is to extend reform to the mental health of the community more broadly. To do that, we need to remove the barriers and boundaries that could stand in the way of change, barriers that many of us have grown up with and grown used to.

There is the boundary between mental health services and agencies that offer employment and training, better housing and social support. Increasingly, services aim to go beyond traditional clinical care and help patients back into mainstream society, re-defining recovery to incorporate quality of life – a job, a decent place to live, friends and a social life.

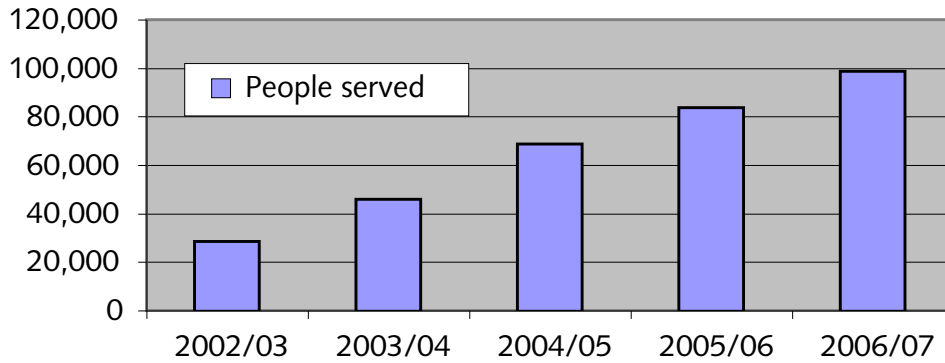
There is the boundary between primary and secondary care. Patients who needed psychological therapies have previously been referred by a GP to a hospital-based specialist. A programme to improve the availability of psychological therapies is based on a new model of service – a single care pathway that allows patients to receive the treatment they need – according to the severity of their illness and how they initially respond to treatment. This will provide quicker treatment without referral for some and easier access to a specialist for others.

There is the boundary between services and the communities they serve. We are asking mental health trusts to go beyond their purely clinical role and engage with local people, particularly those from ethnic minorities, to discuss the services they would like and to overcome the mistrust that can prevent people from seeking help when they need it. Five hundred community development workers will be in post by the end of 2007, working to ensure that patient experience for all ethnic groups is as good as it can be.

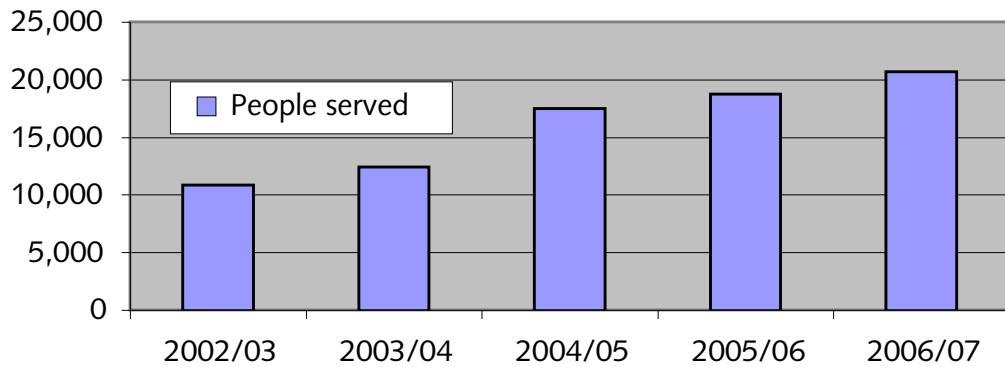
There are boundaries between professions that limit the care that patients can receive. And boundaries between conventional services and the voluntary and private sectors that limit patient choice.

People Treated by New Teams

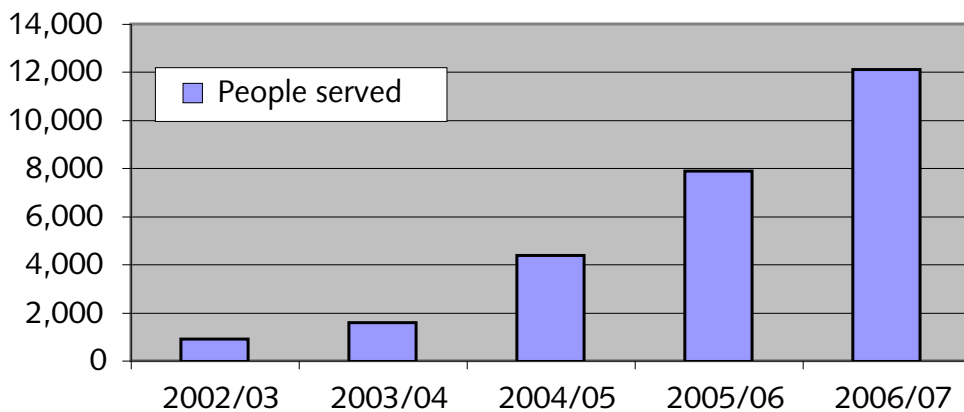
People served by Crisis Resolution teams



People served by Assertive Outreach teams



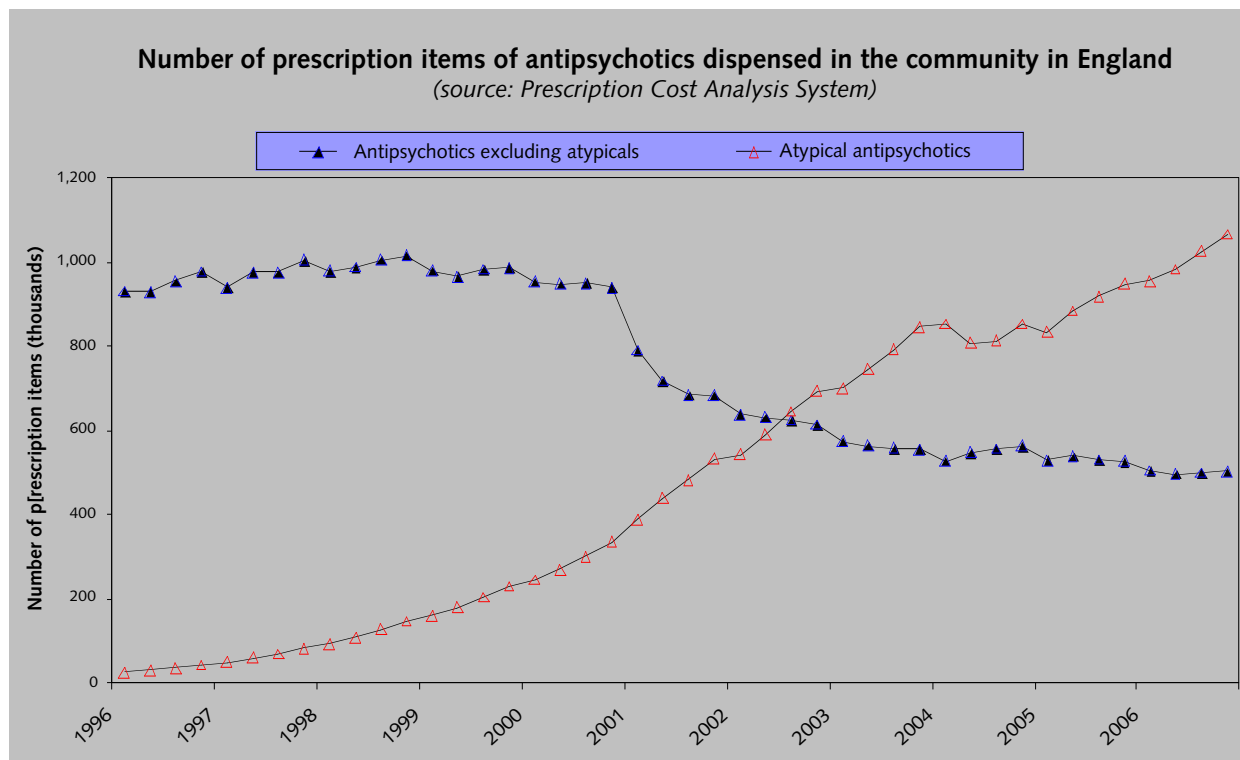
People served by Early Intervention teams



Source: Local Delivery Plan Returns

Technology and treatments

The Use of New Drugs



As in other specialties, mental health patients are benefiting from technological advancements and new treatments. We have already seen much-needed progress in drug treatments and this is directly helping us look after patients in the community – community care cannot exist without appropriate drug therapy.

Ten years ago new drugs for treating schizophrenia were being rationed. In many areas, clinicians could not prescribe above a quota that bore no relation to patient need. Patients preferred these new drugs because they do not have many of the side-effects of the older drugs, but they were considered too expensive. Since then, the use of modern anti-psychotic drugs has increased twenty-fold and they are now prescribed as a first-line treatment.

For conditions such as depression, research evidence has shown that psychological therapies, particularly cognitive behaviour therapy (CBT) are preferable to drugs for most people. CBT is now in great demand and waiting lists have grown to 12 months or more in some places. This is unacceptable and our aim is therefore to increase the number of therapists who have the necessary skills. We need both more staff and to improve the skills of existing professionals.

CBT can also be delivered in computerised form. All primary care trusts are expected to offer this form of self-help from this year.



People like Mary are already using it, not as a replacement for face-to-face therapy but as an extra resource.

“I started using it 15 months ago,” Mary, 57, explained “because I thought it might help me with my fear of people vomiting near me.

“I can’t reasonably explain why it has helped me more than anything else I’ve tried – it just has. It’s made me accept I am going to feel panicky when I go out and that’s all right. I found it pushed me and the fact that it is anonymous, and can be done on your computer at home, gave me time to think.

Mary added: *“Part of my reluctance to seek treatment is because I’m sure people find my phobia boring and don’t want to hear about it endlessly. But you can use it anytime and not have to worry about what people think.”*

New ways of working

As well as more mental health nurses, psychiatrists and psychologists, reform and extra investment have resulted in the creation of new professional roles, such as graduate mental health workers, and new opportunities for professionals to increase their skills.

The expansion in talking therapy services, along with the move to greater community care, will help to continue a process that is requiring all mental health professions to re-define their role in a modern service.

In the past mental health teams have had work delegated by a single professional, often the consultant psychiatrist. We want to create a flexible workforce with redesigned roles for medical staff and nurses, a system where those with the most experience and skills work with most complex patients and support other staff to take on more routine work. The process is leading to greater specialisation for doctors and a larger role for nurses, social workers and psychologists.

Consultant psychiatrists in the future may concentrate on one part of the service, such as in-patient wards or home treatment. Alternatively, they may spend more time on service development or hands-on therapy. We also believe nurses can expand their role to provide patients with more advice on how to reduce alcohol or drug use and how to look after their physical health. No more handing out cigarettes – smoking cessation will become an important role of mental health care.

Michael Phelan, a consultant psychiatrist at Charing Cross Hospital, now works as part of a community health team in a building 600 hundred yards away from the main hospital. His team covers Hammersmith and Fulham and includes nurses, occupational therapists, a psychologist and social services.

“This is very different from when I first started. Looking back and I have to say we were dreadfully disorganised. This now seems a totally logical way to organise a mental health team. Before you had a psychiatrist in the hospital, an occupational therapist somewhere else and we rarely spoke to social services.”

“Now we have different professions with different views talking about cases and that’s a real asset when you are trying to come up with the best decisions for your patients.”

He added: *“The patient is now also integral to the decision making process. I’ve cut attendance at my outpatient clinic. I spend a lot more time doing home assessments and dealing with emergencies. Most of those former outpatients are now taken care of by GPs and through joint assessments, where I and a psychiatric nurse would meet with the patient and discuss the best way of moving forward.”*

“The professional rivalry between the psychiatrists and the psychologists is waning. There is much more openness and none of us think we have all the answers for every patient.”

Patient safety

Every year around 1,300 people who are in contact with mental health services commit suicide and another 50 commit a homicide. Many of these tragedies are preceded by a refusal to take treatment. We are therefore updating the Mental Health Act to allow clinicians the power to treat high-risk patients after discharge from hospital. At the moment, this can only happen in hospital.

Twenty years ago, these same patients might have been in long-stay beds. Today we want to be able to provide them with the best that community care can offer. Without treatment they face a future of recurring illness and repeated hospital admission. Supervised community treatment will give them a chance to stay well and take the opportunities that other people take for granted.

In-patient wards have made substantial efforts to improve



safety – wards in many parts of the country are now bright and therapeutic places. The dilapidated ward that is still part of the public image of mental health care is now the exception, not the rule. Suicide by in-patients has fallen by around 60 deaths per year.

However, we continue to hear reports from in-patients, especially female patients, that they can feel intimidated by other patients. This is the next major safety task for mental health units, to protect and re-assure vulnerable in-patients, separating male and female facilities as much as possible – £30 million has recently been made available for this.

Conclusion

Public expectation, technological advances and an ageing population are driving change in mental health care, just as they are in every other medical specialty. But additional factors such as the stress of twenty-first century city living, significant numbers of people, especially the young, living far from home, and the continuing pervasiveness of drug and alcohol abuse add to the urgency and complexity of mental health care.

We have seen in the last few years a transformation – almost a revolution – in clinical care. There has been a major reshaping of front-line services around the needs of patients in the community. However, changes will not end there.

The next stage in the reconfiguration of mental health services will further strengthen care in the community – breaking down barriers in the way services are delivered. At the heart of these changes will be workforce reform, with the skills of staff more closely aligned to the needs of patients –

modern treatments, a better quality of life, social opportunities and improved physical health.

We are well on the way to a service that staff can be proud of and that patients deserve.



Success on the Ground

In Worcestershire, early intervention services support and care for people aged 14 to 35 who have experienced an episode of psychosis within the last year. The service can be provided in a person's home and may range from medication to specialist psychological support and counselling. Since the service has been in place the percentage of people requiring hospital treatment after their first psychotic episode has dropped from 73% to 43%.