editorial

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So, are things getting better?

It is 3 years since the National Health Service (NHS) Plan was published, 4 years since our National Service Framework appeared. Changing mental health services was always going to be a long-term task, but after 3 years there should at least be signs of improvement, however early. But are there? And where should we look?

Statistical data are collected annually on all parts of the NHS, covering finance, workforce and clinical activity. This is the information that is used in answers to parliamentary questions. It is clear, consistent and unspun. Unfortunately, it is also at least a year old at all times – otherwise, it would be the definitive source of information on current progress. Even so, it can tell us what has been happening in mental health care up to 2001, or sometimes 2002 – in other words, the first year or two after these key policy documents were published. If we look at figures for the final 5 years for which they are available from the mid-1990s, it gives us a kind of before-and-after comparison.

By 2002, spending on mental health services by the NHS had risen to just under £4.1 billion compared with around £3.1 billion 5 years earlier (adjusting figures for inflation), a real-terms increase of over 30%. At a time when NHS spending as a whole rose substantially, the proportion going to mental health rose a little, to just under 13%.

The number of mental illness consultants also rose from 2060 whole-time equivalents in 1997 to 2505 by 2002, a 22% increase. In the same period there was an 8% rise in the number of qualified mental health nurses working in the NHS, excluding agency staff, to just over 38 000 whole-time equivalents. However, the biggest rise was in the number of clinical psychology staff, which rose by around 50% to 6092 by 2002.

Apart from the resources that go into clinical services, one of the biggest concerns of clinicians is that the work has become increasingly difficult to manage as a result of comorbidity, an overemphasis on risk and public expectations. During the 1990s, it is not an exaggeration to say that a crisis in acute care had arisen. It was this crisis that the mental health component of the NHS Plan was intended in part to address – its theme was one of strengthening community care in a way that would take the pressure off acute beds. So what has happened to the number of acute beds? The figures show that the gradual decline in the number of acute beds in the 1990s began to level out in the later part of the decade. The overall fall over 5 years to 2001–2 was around 5%. Well, even if the number of beds is no longer declining we may still as general psychiatrists be required to increase their use, leading to more admissions and reduced length of stay. Yet the number of admissions annually gradually declined throughout the 1990s to 178 000 by 2001–2002, while the average length of stay did not change.

However, any general psychiatrist knows that the problem is not simply the volume of work but its nature – patients with complex problems, perhaps including drugs and violence, requiring admission under the Mental Health Act 1983. Yet the figures show that the number of people admitted under civil sections of the Mental Health Act 1983, having increased markedly during the early 1990s, has been fairly stable since 1998. Overall, then, the evidence appears to be giving a coherent picture. We may have a long way to go before the problems that have plagued acute clinical care are resolved but at least they seem to have stopped getting worse.

Most importantly, what do we know about the new services that are intended to reshape what we provide? The period 2001–2002 was the first year in which substantial new NHS Plan money was allocated, but many services started earlier, realising what would be required as soon as the Plan was published. We now have over 190 assertive outreach teams nationally and 62 crisis resolution teams offering home treatment. Early intervention services have made a slow start – there are 21 nationally making satisfactory progress (although only a handful are adequately staffed teams), but the pace of change is too slow if the new services are to be up and running by their target dates.

No one would deny that we have a long way to go in transforming the state of mental health care – there has been progress but it has been patchy and in itself insufficient. There are serious problems in some local services and we are still some way off the standard of care that patients deserve and that staff would like to deliver. At the same time, it would be wrong to dismiss

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these early signs of improvement: it would be unfair to those who have worked hard with their local commissioners to make sure that mental health is no longer neglected; it would give the wrong message to patients who need to have confidence in the services that they use; and it would not be a good tactic if we want to remain an NHS priority.

The next 2–3 years are now critical. In the new NHS, with commissioning power firmly devolved to primary care trusts, there is no certain way for the Department of Health to centrally dictate where the resources will go. We can use the star rating system to set the priorities, although in the end it is the Commission for Health Audit and Inspection that will award the stars, and we can monitor spending plans and support developments through the National Institute for Mental Health in England; but equally there are points of influence at local level, through implementation teams, primary care trusts and strategic health authorities. More than ever before, making sure that things get better is a shared responsibility.

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