London's mental health services

David Goldberg

The King's Fund for London has just published the findings of the four groups of researchers from whom it commissioned work on the mental health service needs of Londoners and how far current services meet these needs (Johnson *et al*, 1997). Later in the year the London Commission will make recommendations that are informed by these findings, and will suggest a comprehensive pattern of health services to serve London into the 21st century, and indicate how such a pattern might be brought about by a carefully managed process of change. The first London Commission published its report in 1992 (King's Fund, 1992), but did not consider mental health services or services for the elderly. Four groups were asked to address the state of London's mental health services: the PRiSM team at the Institute of Psychiatry, the Centre for the Economics of Mental Health, the Centre for Mental Health Services Development (at King's College London), and the Research Unit of the Royal College of Psychiatrists.

The picture that emerges is far from reassuring. London shares the problems of other large English cities, but every measurable problem appears to be present to a greater degree. Thus, for London as a whole the number of finished care episodes (FCEs) is greater, especially for young men, and there are more admissions with schizophrenia. When inner deprived areas of London are compared with inner deprived areas of other cities, there is higher bed occupancy, very much higher rates of admission to medium secure units, more patients compulsorily detained, and more patients with drug-related problems. The patients who are admitted are on average more severely ill, and more aggressive, and a greater proportion are from ethnic minorities.

These differences can be related in turn to differences between London and other cities: London has six of the most socially deprived areas in the country, a higher unemployment rate, greater numbers of homeless, almost double the number of single person households, and more of its population are in the risk years for psychotic illness (15–45 years of age).

In-patient beds are being used inefficiently because there are insufficient numbers of residential placements in the community. There are especial shortages of 24-hour nursed places in the community, as well as less intensively staffed residential facilities – where there is a tenfold variation in supply across the city. The concentration of resources on attempting to meet the needs of the most acutely ill has been associated with limited and patchy provision of other important elements in long-term care, such as day care, family interventions and employment schemes. Local Authority Services are not playing the part they were intended to in the provision of care for the adult chronically mentally ill, although they have a better record with care of the elderly. The studies have identified problems in staff recruitment and morale, as well as a generation of managers who are not able to deal with the process of change.

The report covers services for all specialist mental health sectors, as well as services for ethnic minorities, and primary care services. No part of the long report provides any evidence for complacency. In particular, community mental health services are found to have been introduced in a way that is cost-cutting and incomplete, so that many aspects of care in the community cannot be provided in a satisfactory way.

London's purchasers were found to spend more of their total health budgets on mental illness (18.6% in London, 13.7% in other cities): the fault appears to be in the formulae for allocating resources to purchasing authorities, rather than in the miserly behaviour of the purchasers. Capitation payments need to acknowledge a greater need in deprived inner city areas, and ways are available for taking this into account. Carr-Hill *et al* (1994) have produced a formula which would allocate resources according to a weight for the acute sector, and another for the psychiatric sector. The former takes account of standardised mortality, unemployment, elderly living alone and proportion of dependents in single carer household, while the latter takes account of six variables derived from Census data. The Department of Health has only partially acted on this advice: a third "unweighted" column has been introduced, which was not the intention of the York team. The effect of this unweighted column has been to greatly reduce the allocation to deprived inner city areas. Full introduction of the York formula would redistribute resources to inner city areas at the expense of rural areas and dormitory towns, and would go a long way to

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remedying the present inequalities (Health Committee, 1996).

The research for the London Commission has shown that Glover's Mental Illness Needs Index (MINI; Glover, 1995) does not perform well in predicting needs in inner city areas. This is for two reasons: the index assumes that needs are normally distributed – they are not; and the estimates upon which the MINI was based are no longer realistic. It is possible to remedy these defects, but the MINI as originally conceived under-estimates the needs of deprived inner city areas.

The report includes an important section on the cost implications of the findings. Outer London is found to be functioning at approximately the predicted levels of expenditure, but nine authorities in inner London are substantially underspent to the tune of £3–4 million each. These cost differentials are analysed by type of facility, which shows substantial underspending on acute beds and 24 hour staffed accommodation in both inner and outer London. There is little comfort for anyone in any of this: if care in the community is to work, there will need to be a substantial rethink from central government to ensure an equitable service in our inner cities.

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