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Mental health services and resources*

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Of the very large sum of money spent on mental health services, almost all comes from the public directly in the form of central or local government taxation. In 1990, approximately £2 billion was spent in the National Health Service directly on mental health services. That represents 10% of total health service expenditure. In addition, local authority social services departments spend around £50 million annually on residential and day care services for people with mental problems. A further £100 million is spent on supplementary benefit for board and lodgings payments and a considerable amount expended by prisons, courts and the police. These figures omit the growing amount of money spent on supporting elderly people with senile dementia outside mental illness hospitals, in residential and nursing homes. Almost two thirds of all residential care for elderly people provide care for those with mental disorder, adding a further staggering £5–600 million by 1990. The current direct care costs of disabling mental disorder to the public purse is approximately £3,000 million (£3 billion). For all the huge amount of money, resources appear inadequate, ill-directed and uncoordinated. Several actions need to be taken to improve the use of these vast resources.

The role of Joint Finance

In the 1960s and 1970s it was assumed that, as hospital beds closed, money would be transferred from the health service to local authorities to provide alternative facilities. To promote the transfer of resources an ear-marked fund was established in 1976, called Joint Finance, carved out of the health service national budget, but to be specially allocated on schemes provided by local authorities or voluntary organisations on the agreement of plans put forward by both authorities. Joint Finance was the carrot to promote greater joint working of the divided public sector.

Our judgement is that Joint Finance has been only a modest success. It made a small contribution to developing some innovative demonstration projects, but it represented only 1% of NHS total expenditure and had to cover services for elderly people, people with physical disabilities, children and adults with mental handicap as well as mental health services.

Joint Finance grant was a specific sum allocated to a project for a number of years, then gradually tapering off, with the intention that the local authority would pick up the bill. As local authorities' budgets grew tighter, the authorities naturally became reluctant to commit themselves to additional expenditure for seriously dependent people in years ahead for which their income could not be predicted. In many localities the money was spent in later years on temporary support to voluntary organisations and schemes with a minimal impact on the overall shape of services.

The decline in local authority commitment of funds

The fact that Joint Finance existed may even have discouraged health authorities from transferring money directly from their own budgets to local authorities. There were other disincentives. Existing funding arrangements heavily penalised those local authorities which decided to invest in community care services.

The development of mental health services depends crucially on the willingness and ability of local government authorities to spend money on providing the right kind of housing, rehabilitation facilities, and social care support in its widest sense, including the leisure and education facilities which other citizens enjoy. Since the early 1960s, the balance of power has shifted significantly away from local government to central government. Relations between central and local government have been systematically eroded by a series of measures designed to keep the lid tightly closed on local authority expenditure of any kind. The response has been predictible in the reactive rise of angry profligacy by those on the left of politics and in the total failure of some right-wing dominated authorities to spend anything at all on social welfare services for disadvantaged minority groups. It is not surprising that, as hospital closures have proceeded in the health service, local authorities have not responded by developing the range of alternative services envisaged in the 'Hospital Plan' of 1962, imaginatively promoted by Mr Enoch Powell, then

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Minister of Health. The 1975 White Paper, *Better Services for the Mentally Ill*, repeatedly referred to "economic stringencies" and indicated that the government expected no improvement in local authorities' commitment to mental health "until economic circumstances permit". Central Government expected nothing; most local governments naturally did nothing.

In order to restrain overall public expenditure, the government reduced the allocation of central grant if an authority spent more by raising rates, or now, poll tax. 'Rate capping', or 'poll tax capping', that is preventing local government from raising rates and poll tax, remains the ultimate weapon. Small wonder then that authorities did not want to commit themselves to taking up Joint Finance, or even to accepting transfer of funds direct from the health service. For every million pounds an authority spent extra on community care services, a burden of up to £2 million could fall on rate-payers because of loss of central grant, unless other services were reduced, commensurate with the cost of developments.

In-patient costs

All bureaucracies have a natural tendency to hang on to their own resources. The health service has retained mental health funds mostly in the form of hospital beds and there has been minimal transfer of resources to local authorities.

During a time when thousands of beds closed between 1975 and 1985, money invested in in-patient beds remained more or less the same, and still represents over 84% of the total expenditure from public authorities on mental health. However, whereas mental health's share of the National Health Service cake remained steady over that ten-year period, the cost of an in-patient bed doubled. In part this was due to much-needed, increased staffing levels of acute psychiatric beds with nurses, occupational therapists, psychologists and doctors, and improvements in the community psychiatric nursing services, and in part to the less admirable direct shift of resources out of long stay care beds into new acute psychiatric units developed in general hospitals.

But the key reason for the dramatic increase in in-patient costs is that, as patients have died or left hospital in a haphazard way, there have been only marginal savings on the overall costs of running a hospital. To save significantly on staffing costs, a whole ward of 20–30 people has to be closed at once. To save overhead costs such as water, light and heating, a whole ward block of 50 to 100 people has to close. To save the enormous costs of building and grounds maintenance of decrepit Victorian institutions and of support services, like the administration department, catering and pharmacy, the whole hospital has to close. When half a dozen patients move out of hospital into a home of their own, there are minimal savings in the hospital that can be made available for care in the community.

The need for bridging finance

In order to develop services outside the hospital, bridging finance is required for many years until all the money can be finally released on the closure of the hospital. This applies as much to the capital costs of building, converting or leasing property for residential and day care. While in theory the costs of community provision should easily be covered by the money from the sale of large hospital sites, some of which are in prime residential or commercial development areas, the income cannot be realised while the hospital is still partially occupied. Large capital sums are required 'up front' to provide alternative accommodation and these have not been forthcoming.

In the 1980s, regional health authorities introduced capital and 'ongoing revenues' bridging funds in a small way, usually targetting one or perhaps two institutions in their regions. But the funds were simply inadequate to cover the need. The inexorable decline of beds was not halted and patients continued to move out into places which cost the health service and local authority nothing.

The new "trade in lunacy"

Since the rundown of hospital beds began, patients who were thought fit for discharge, but who had no family or friends to return to, tended to drift to inner city areas where cheap hotels and hostels for single homeless people attracted those seeking anonymity and basic shelter and food for a small sum of money, well within welfare benefit limits.

But in the 1970s a new trade emerged. It began at English seaside resorts, where landladies running cheap private hotels and bed and breakfast accommodation were starved of their usual summer visitors as wet summers and cheap package holidays swept British holiday-makers off to Spain and other sunny destinations. Ex-psychiatric patients were attractive alternative customers. They were resident all year round, funded generously enough by social security benefits, generally quiet and socially reserved, amenable to institutional life, and often inept at complaining if the circumstances they were living in were unsatisfactory. Besides, once the hospital closed behind them, there was no way back. They were welcomed by proprietors who generally had no experience whatsoever of the needs of their residents and even less understanding of their mental disorders.

In any seaside town on the south coast in the 1970s you would find dozens of dispirited, isolated, middle-aged and elderly people, unemployed, spending most

of the day walking along the beaches and around the town or in cheap cafes and public libraries, locked out of their lodgings during the day. Many of these establishments were characterised by multiple occupancy rooms with beds squashed into every corner, poor washing and bathing facilities and a total lack of any social amenities. This was the latter-day version of the private madhouses of the 18th century. Many consultant psychiatrists working in mental hospitals discharged their patients to these 'homes', quite unaware of the reality of the conditions to which they were consigning their patients.

Most of these private homes are now registered with the local authority, and are regularly inspected. Conditions have improved, but the residents remain an additional, unsought responsibility on local social services and often on the district psychiatric services too. The rapid development of asylums in the 19th century was encouraged by the drive of local parishes to shift financial responsibility for long term care on to county council asylums. In the late 20th century a curious and complex set of financial arrangements provided incentives for both health and local authorities to shift responsibility onto another central funding source, the Department of Social Security.

Concentration of resources on old long stay patients

By the late 1970s there was no-one left in long stay wards in mental hospitals who could easily be discharged without follow-up. Those remaining were either too physically sick and old, or too emotionally or behaviourally disturbed, to be discharged to unsupervised homes, or too dependent on other people for help with the daily tasks of life – washing, bathing, feeding and so on. The options were few; either they had to go to the increasing number of private nursing homes and residential homes springing up for elderly people, or alternative provision had to be planned using health service money. Large numbers of physically disabled, elderly people who were considered sufficiently well-behaved and free of excessive mental symptoms were moved into ordinary private residential nursing homes; the most seriously disturbed were left behind.

The further reorganisation of the health service in 1983 created mental health or "priority care" units of management in which health service elements of the service were all planned and managed under one responsible unit general manager. On a wave of optimism considerable capital investment was achieved in the mid-1980s. It was too little, too late. By then, most of the damage had been done – 20 years of thoughtless discharge of vulnerable patients could not be undone. New plans have focused exclusively on the replacement services for the patients who had been left behind in the institution. As we are all keenly aware, there is now no new money for the ever-increasing numbers of new patients with long-term needs, recycling through the new district general hospital acute psychiatric units on a constantly 'revolving door' and the many chronically ill people who have no contact with services and are receiving no help at all.

Patients who moved to private sector board and lodgings, or residential homes, were rarely followed up by the consultant or his team, beyond the first few weeks. The distance between the hospital and the area where cheap, large properties suitable for conversion to institutions were plentiful was likely to discourage visiting. The health service effectively shuffled off high cost inpatients to a low cost system remote from statutory services.

The new proposals

The perverse funding systems have acted as a serious disincentive to collaboration between agencies. Large sums of money remain 'locked in' to partly occupied old hospitals, and local authorities are discouraged from spending appropriately.

The NHS and Community Care Act 1990 proposes some streamlining of funding arrangements so that social security benefit for residential care is channelled through local authorities, following an assessment of an individual's needs. This should have the effect of improving the targetting of these funds, but will also impose a cash-limit 'ceiling' on the government's expenditure in this area. These changes, however, will not now take effect until 1993. From April 1991 there will also be a specific mental health grant for Social Services to use on provision of community services. The funding arrangements for this are similar to Joint Finance. The sum available is small, and it is unlikely to have any significant impact on service development.

The Treasury has also given a cautious nod in the direction of some private developers to loan money in advance of the sale of hospital sites to provide bridging finance for community-based replacement services, but the complex rules and reluctance to allow private developers to make risk-free profits suggest the Treasury is more ambivalent about these unconventional finance arrangements than at first appears. What is required is a far more generous incentive to private property developers, local authorities and housing associations to provide bridging finance.

Lack of personal resources for patients

We often talk of resources in terms of money available to public and independent sector organisation,

but the individual sufferers involved see things more starkly. Most patients and their families simply have insufficient money within their own control to make choices about how they wish to be helped. Money empowers people to choose for themselves what kind of accommodation they need, to decide how much help with household chores they require, to pay directly for help from neighbours or private agencies. Money doesn't solve everything, but it gives a sense of mastery over some of the options. Specific welfare benefits, such as attendance allowance and invalid care allowance, make a small contribution to the care of some individuals, but the sums are small, compared to the costs of providing residential or hospital care. Inadequate personal income and inadequate help with maximising benefits which *are* available is a problem for many mentally disordered people and their relatives. This aspect of mental health needs urgent attention. Considerable help can be provided to individuals by the appointment of welfare rights officers in hospital, and we commend that minimal course of action to you.

Staffing levels

There is a dubious assumption that the present staffing levels are appropriate, both in number and in the qualifications of the people in post. When the Independent Commission looking into the role of occupational therapy undertook the staffing survey, it found that only 49% of occupational therapists working in mental health services were qualified professionals. The establishment figures for occupational therapy staffing varied from region to region so greatly that it was difficult to understand the rationale. National figures for manpower shortfalls of 25% in the NHS and 37% in local government add enormously to the general difficulties of trying to provide good quality services.

Local variability of commitment and funds

There remain extraordinary disparities between one area and another in the commitment of funds from local authorities and health authorities to mental health services. For example, in 1986, inner city North East Newcastle-upon-Tyne spent £7.43 per head of population on mental health services, while Redbridge, a prosperous suburban outer London district in the South East, spent £0.49 per head. Health service spending varies as much. In 1986 Mersey region spent over double what Oxfordshire region spent per head of population. To make matters worse, there is no inverse correlation between the disparities in one locality of health and social services authorities' spending. The financial allocation is just as likely to be very bad in both authorities, as it has been for example in the London Borough of Lambeth and West Lambeth Health Authority, or very good in both authorities, as traditionally has been the case in Newcastle. The growth of private sector nursing homes and specialist hotels has been in those areas where cheap large houses were available for conversion or in traditional holiday areas. Prosperous rural and coastal areas are often over-provided with this sort of accommodation, whereas inner city areas which have far more people with serious mental disorder living there, are desperately short of places. *There need to be much clearer local targets set for services by government to ensure all health and local authorities meet their local responsibilities.*

Resources are not just financial

Finally we would stress that the problems of community care are not just financial. Government money, channelled by way of local government and the health service, or going directly into the pockets of sufferers and their families through income support benefits, is a key necessity for effective community care services. But it is not enough on its own. More and more money from public taxation has been put into the services, and yet the services still do not work in a foolproof way. Future services must be structured and organised in ways which also take account of the characteristics of mental disorder. The real resource required is *people* – trained, committed, ambitious to improve the quality of the care they offer. Further financial resources are needed, but they can be used effectively only by a service which is led by the vision of a better quality of life for all mentally disordered people.

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