

Mental health service provision in England

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Objective: To describe mental health service provision for adults of working age in England.

Method: Services in an inner London area are described so as to illustrate current patterns of service organization in England. National trends are then discussed.

Results: Despite relatively low public expenditure, substantial progress has been made in deinstitutionalization and development of comprehensive community-based services. Persisting difficulties include high staff turnover, a minority of patients who do not engage with community services, user and carer dissatisfaction with emergency services, and social exclusion because of stigma. Recent government policy advocates resolving some of these problems using new service models such as assertive outreach and crisis teams.

Conclusion: Closure of the large asylums has largely been accomplished. England is now entering a new phase in community service development, with a range of innovative developments aimed at resolving problems still encountered after the initial phases of integrated community service development.

S. Johnson¹, M. Zinkler², S. Priebe³

¹Department of Psychiatry and Behavioural Sciences, Royal Free and University College Medical School, London, ²City and East London Mental Health Trust, London and ³Unit for Social and Community Psychiatry, St Bartholomew's and the Royal London School of Medicine, London, UK

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Dr Sonia Johnson, Department of Psychiatry and Behavioural Sciences, UCL, Medical School, Wolfson Building, 48 Riding House Street, London W1N8AA, UK
E-mail: s.johnson@ucl.ac.uk

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Introduction

Mental health service policy and service provision in England have been characterized not by the single-stage introduction of a wide-ranging policy of reform but by continuous development towards more community-based care over half a century. New government policy has been introduced frequently over this period, sometimes seeming to drive the process of change forward, sometimes to reflect changes which have already taken place in many areas. Substantial variations have persisted between areas in the services available, variations which the UK government is seeking to reduce through development and implementation of the National Service Framework for Mental Health (1) and the subsequent NHS [National Health Service] Plan (2).

In this paper, we will first provide a snapshot of the current state of mental health services by describing service provision in the London catchment area in which the first author works. We

will then discuss the extent to which this snapshot is typical of the current state of mental health care across England. We will identify some strengths of the current system, and will then describe major problems which continue to be debated. We will outline some of the proposed solutions to these problems, including those proposed in the National Service Framework (1) and the NHS Plan (2). This paper is concerned only with NHS provision: while the private health care system is an important provider of psychological treatments such as psychodynamic psychotherapy, its role in treatment of severe and enduring mental illnesses is a marginal one. We have focused on England alone, as countries within the UK have had differing policies and patterns of service development. The scope of our discussion is limited to specialist mental health care for adults of working age: many important issues relating to other psychiatric subspecialties and to mental health care in primary care are thus omitted. Our

account is based where possible on published data, but we also draw on our experiences of working in, researching and discussing mental health services in England. The views we express are our own, and not the official ones of any institution or public body.

A snapshot of mental health service provision in England: the London Borough of Islington

In this section, we will describe the services provided for the population of the London Borough of Islington. Islington is a socio-economically very mixed area of Inner London, in which the extremes of British society are over-represented, with enclaves of wealth among areas of considerable social deprivation. Around 20% of the population of 175 000 come from ethnic minority backgrounds. For mental health care provision, the Borough is divided into five geographical sectors of approximately equal size. Currently boundaries between sectors are geographical, with each sector covering a number of electoral wards. So as to strengthen links between primary and secondary care services, plans are being made to change to sectors based on general practitioner lists, with each sector covering a group of local general practitioners.

Services provided at sector level

In-patient beds

Each geographical sector has a community mental health team and dedicated beds on an acute in-patient ward. The acute wards for all the geographical sectors are based together in a single unit built around 30 years ago next to the district general hospital. The management of the local mental health service is, however, largely separate from the general hospital. The large asylum serving the area closed in 1993. Demand for acute admission beds has considerably outstripped supply for several years, so that the NHS is usually paying for a few local patients to occupy acute beds in private hospitals and there are considerable pressures to avoid admission and to discharge patients early. On one day in March 2001, 72 acute beds were occupied by residents of Islington aged between 18 and 65 years. Two small wards in local hospital units are designated 'intensive care units', providing more intensive staffing for particularly disturbed patients, and six patients from Islington were placed on these wards. This gave a total acute bed use of 41 per 100 000 population. Around 50% of these

patients are likely to have been compulsorily detained in hospital under the UK Mental Health Act, and more than half are likely to have a diagnosis of psychotic illness of some form (3). Over the space of 1 year between 1998 and 1999, 1115 compulsory detentions under the Mental Health Act (4) took place in the wider catchment area of which Islington formed part, Camden and Islington Community Health Services NHS Trust — this area has a population of approximately 272 000.

Residents of Islington also have access to two innovative crisis houses. These are non-hospital facilities which admit patients in crisis and are staffed 24 h a day. One is a women-only facility funded by the local mental health Trust, which admits 12 women at a time for a maximum of 4 weeks. It occupies a large nineteenth-century house in a residential street, and is intended to serve women who would otherwise have required admission to a psychiatric ward. Most women who use this facility have a previous history of admission to psychiatric hospital and appear to be managed safely at this house (5).

Islington now has no designated long-stay wards, although two small wards have rehabilitation in-patient beds to which residents of Islington or neighbouring Camden may be admitted for longer stays. Most in-patient stays on acute wards are finished within a few weeks, but a handful linger for many months on the wards, mainly because of difficulties in finding appropriate accommodation. Moving these 'new long-stay' patients on from the acute wards has often presented considerable problems to clinicians and managers, and a new multidisciplinary accommodation team including nurses, social workers and a psychologist has recently been established to carry out detailed assessments and seek appropriate placements.

Community mental health teams

Each of the five Islington sectors has a community mental health team, which has responsibility for the community and out-patient management of people with severe mental illnesses within its boundaries. An example is the team in which the first author works, which is responsible for an area with a population of 38 000. The team works from a community health centre close to the centre of its sector, in a slightly run-down local authority building where there is office space, a meeting room and a few small interview rooms. It is shared with a social services team providing care for the elderly and physically

disabled. In 1998, the community nurses, social workers and psychiatrist moved to this office from their previously separate bases, and began working together as a much more closely integrated team. The team leader is a senior nurse. The team of 16 includes an occupational therapist, a half-time clinical psychologist, a half-time consultant psychiatrist and two part-time junior psychiatrists: around half of the rest are community psychiatric nurses and half social workers. Most members of the team have at least 2 years postqualification experience and several more than 10 years.

The team hours are Monday–Friday, 9 a.m.–5 p.m. Each morning one of the professionals in the team is responsible for receiving and deciding how to deal with all new referrals to any professionals in the team (including psychiatrists). New referrals, clinical problems and liaison with other agencies are discussed each week at a 3-h meeting attended by all team members.

All team members except the psychiatrist have a case-load of patients identified as having severe and enduring mental illness for whom they are care co-ordinators. The Care Programme Approach is a set of principles for organizing mental health care which all UK mental health services have been required by law to implement since 1993. The major principles are as follows:

- Each patient identified as having a severe and enduring mental illness must have an identified care co-ordinator, who is an experienced mental health professional. The care co-ordinator is responsible for keeping in touch with the patient, offering support and responding to any major change or crisis, organizing reviews, checking that all the services in contact with the person are working together in a co-ordinated way and making sure that the care plan (see below) is put into action.
- There is an identified consultant psychiatrist responsible for medical input to the service user's care. This is generally the consultant working with the team.
- There are regular reviews of the individual's needs for clinical and social care, following which a care plan is drawn up.

In the Islington team being described, the average case-load for full-time staff is 25, with 230 patients on the team's case-load. Some staff have smaller case-loads because of management or other responsibilities. Some patients come to the centre to meet with care co-ordinators, but a greater proportion are visited at home, and staff are usually also in regular contact with informal

carers. The usual frequency of contact is every 2 or 3 weeks, with weekly contacts for patients with a high level of need or who have recently been discharged from hospital or appear to be deteriorating. More frequent contacts can sometimes be offered for short periods when patients are in crisis, but are not a routine part of the service. Around 60% of team patients have schizophrenia, schizoaffective disorder or bipolar affective disorder and most have had hospital admissions.

Reviews of need under the Care Programme Approach usually take place every 6 months. A review is also held close to the time of discharge if a patient is admitted. The care plan drawn up lists contact details for all involved in the patient's care, diagnosis and medication, clinical and social needs identified and plans made to meet these, early warning signs of relapse and plans for crisis management. Reviews usually last around half an hour and are attended by the patient, care co-ordinator and psychiatrist. Informal carers and other professionals involved in patients' care such as day centre workers and housing support workers are often also invited. These reviews are the main occasion on which patients have regular contact with the team's psychiatrists, but care coordinators arrange extra meetings with psychiatrists if concerns arise.

Out-patient clinics for the sector are also held at the centre. Around 150 more stable patients who have no team care co-ordinator are followed-up in these clinics, and around three patients a week are seen for a single assessment and referred back to general practitioners with advice on continuing management in primary care.

Assertive outreach and crisis resolution teams

Three new community-based teams have, in the past 3 years, been added to the five sector community mental health teams. One is an assertive outreach team with a case-load of 65 patients. It has 10 members including a half-time consultant psychiatrist, a half-time clinical psychologist, an occupational therapist, community mental health nurses, social workers and a community support worker. The team's target group have had frequent admissions, present a substantial risk to themselves or others and have not engaged well with community mental health teams. The team is available 7 days a week and works mainly in patients' homes or any other community settings in which staff are able to find and make contact with patients. Staff have more time available to spend with each patient than in

the community mental health teams, and make varied and multiple attempts to engage and keep in touch with patients. They aim to build close relationships with clients and plan together ways of tackling problems in areas including social networks, finances, benefits and budgeting, accommodation, leisure, use of substances, occupation and health. Where required, they visit patients daily to give them medication. Discharge is planned only when considerable stability has been achieved.

Two crisis resolution teams have also been established in the past 2 years, one working in three mental health sectors in North Islington and the other in two sectors in South Islington. Members of each team include a junior psychiatrist, community mental health nurses, social workers and community support workers. The consultant psychiatrist in the sector where the patient lives retains responsibility for senior medical input during the period of crisis team treatment. One team is led by a nurse, the other by a social worker. The service targets patients with psychiatric disorders for whom, in the absence of a crisis team, acute hospital admission would be seen as necessary. Other mental health services, primary care services and the police are among the agencies who refer to the team, and patients also refer themselves. The team is available 24 h a day and assesses, treats and supports people in psychiatric emergencies in their own homes, or whatever setting is most appropriate to successfully engaging and managing them. The team aims to respond to emergencies within 1 h, and to see any patient for whom hospital admission is being considered, so that the feasibility of intensive home treatment can be considered. Where hospital admission is considered necessary despite the team's availability, the team aims to facilitate an early discharge with intensive home support. If required, they can visit patients several times daily and for extended periods during the emergency period, offering advice, monitoring, help with social problems and medication management.

Both assertive outreach and crisis resolution teams adopt a team model of working, where patients are have contact with several members of the team and staff aim to combine their various skills to plan effective care. At the time of writing, the teams are still in a start-up phase: randomized evaluations and phased increases in case-load mean that they have not yet reached their full working capacities and cannot yet be expected to have had their maximum impact on acute bed use.

Other residential services

Within the Borough of Islington, a range of specialist housing schemes provide places for people with mental health problems, many managed by voluntary sector (charitable) organizations. These range from hostels with 24-h staffing to supported flats where a worker visits tenants weekly for practical support and monitoring. However, many schemes are full, and considerable delays and difficulties often arise in finding appropriate places. Finding placements where individuals with comorbid severe mental illness and substance misuse can be supported presents particular problems. The main emphasis in planning new residential schemes is on increasing provision of supported tenancies, where service users live in independent flats close to a central office at which specialist support staff are based. Daily visits from these staff can be provided in some of the schemes, but once the patient is more stable and this has been withdrawn, patients can usually retain tenancy of the same flat. Accommodation of this form is currently favoured, as many younger service users who have never experienced long-term institutionalization are reluctant to move to traditional hostel settings, where they feel they will lose privacy and independence to an unacceptable extent. These schemes also provide patients with a long-term home which they will not lose if their support needs diminish.

Other mental health services

Islington also has six mental health day centres, where social contact, support from staff, creative and recreational activities and support groups of various forms are available in a relatively informal setting. Some also have limited work training or work placement schemes, although in general availability of training for work, supported placements and sheltered work settings is very limited. The majority of users of these centres have a history of contact with specialist mental health services. One of the day centres is dedicated to black Caribbean and black African service users. Another provides a programme of psychotherapeutically oriented groups. Service users can attend these centres long term. At the acute psychiatric in-patient unit site there is a day hospital: this is not an emergency facility, but provides longer term care including psychotherapeutically oriented treatment and occupational therapy.

Current service provision in England

There are some major respects in which this snapshot is representative of current service provision in England and Wales. Bed numbers in the large asylums have been falling since a peak in 1954 of 152 000 people occupying psychiatric beds. Eventual closure of the large asylums has been government policy since the early 1960s, and, although implementation of this policy has been slower than initially envisaged (3), most have now closed or have only a small fraction of their original patient populations still resident. While heated debate persists about many other aspects of service provision, there is now a substantial consensus among mental health professionals and managers that most long-stay in-patient beds outside secure hospitals can be replaced by community alternatives. Support for this comes from the TAPS study (6), a large prospective study of outcomes for 670 long-stay patients discharged from two inner London asylums. Although a small minority proved very difficult to resettle successfully in the community, in general placement of long-stay patients in the community appeared successful, with few problems with crime or vagrancy. Positive changes were reported in quality of life and social networks after discharge, and patients generally wanted to remain in their community placements.

Most of the hospital beds dedicated to mental illness are now acute or secure beds. Figures for bed use in Islington are typical of areas with high levels of social deprivation, where acute bed use, rates of compulsory detention and proportion of in-patients who have psychotic illness have generally been found to be considerably above the national average (3). National statistics for 1999/2000 indicated that of 186 290 National Health Service beds in England, 34 173 were dedicated to mental illness and 6834 to learning disability (7). Excluding beds for children and older adults over 65, there were 14 118 short-stay beds available for the mentally ill, 1882 in secure units and 4305 long-stay beds; 90.5% of the available bed days in short-stay units, 92.9% in secure units and 86.6% in long-stay units were used. Three years previously in 1996/7, 37 640 beds were dedicated to mental illness, including 14 504 short-stay beds for adults under 65, 5424 long-stay beds and 1575 secure unit beds. Thus a small fall has occurred in long-stay bed numbers, but not in acute or secure unit bed numbers.

Figures on use of these beds in 1999/2000 show that 155 121 admissions were completed in

England for adults under 65 (8). The mean length of these admission was 52 days, but the median only 17 days. The predominant diagnoses specified were schizophrenia, schizotypal and delusional disorders, accounting for 36 806 admissions (median stay 31 days, 59% of patients male), mood disorders with 54 515 admissions (63% female, median stay 31 days) and neurotic, behavioural and personality disorders with 30 418 admissions (57% female, median stay 8 days).

Turning to community services, the pattern of service provision found in Islington is representative of areas which have been relatively quick to implement new service models and policy directives. Sectorization, care by multidisciplinary community mental health teams and implementation of the Care Programme Approach are almost universal features of community care provision across England. Sectorization occurred in most areas in the 1980s, even though it had not as yet become government policy at the time (9). Similarly, multidisciplinary community mental health teams which carried out much of their work in patients' homes were almost ubiquitous by the time they became government policy around 1995 (10). However, in many areas it has taken some years for these teams to obtain premises within their small geographical sectors, so that in some areas they have continued to work from offices in the local hospital: for example, in London in 1996, only nine of 27 local authority areas surveyed had community mental health centres in every small geographical area, while three areas had no such centres (11). The degree of integration between NHS mental health and social services also varies. Government policy now requires plans to be made for social workers employed by local authority to work in joint teams with NHS mental health professionals, as described above in Islington. However, there is considerable variation in the extent to which these plans have so far been implemented. The care co-ordinator system and the reviews of needs and service co-ordination required under the Care Programme Approach appear now to be implemented throughout the country.

No recent published national data appear to be available on the extent of provision of crisis teams and acute outreach teams, but many such teams appear to have been established in the past 5 years and, as discussed below, recent government policy will disseminate these models more widely. Day centres and residential accommodation are generally available, but the forms these take and levels of provision vary considerably and, at least until recently, these forms of care

have often developed piecemeal, with little planning at catchment area or regional level. Acute day hospitals are available as a component of emergency services in some areas, but absent in others. There is currently substantial interest in the crisis house model of care, exemplified in the women-only house in Islington, but it is not as yet widely disseminated.

How far has community mental health care been successfully implemented?

Thus substantial strengths can be identified in services in England, despite a relatively low national spend on mental health services (12). There has been considerable progress towards deinstitutionalization and the development of community-based multidisciplinary care, even though the pace of change and patterns of service delivery have varied between areas. Thus it may seem surprising that in 1998 the following announcement appeared in the *British Medical Journal* (13):

The abandonment of care in the community for people with mental illness as it has operated in England for more than 20 years was signalled in parliament this week by the health secretary, Frank Dobson ... Mr Dobson acknowledged that care in the community had failed. Too many vulnerable patients were being left to cope on their own, creating a danger to themselves and the public.

This statement was widely publicized, although subsequent more detailed policy statements indicated that, apart from some expansion of secure bed provision, no large-scale reinstitutionalization was envisaged. However, current community care arrangements were seen as inadequate in a number of respects, and subsequent policy, including the National Service Framework and NHS Plan, has proposed substantial changes. How far these statements about the failure of community care reflected reality and how far they were a disproportionate response to skewed and stigmatizing media reporting on mental health issues continues to be debated. However, there is evidence that, whatever the achievements so far of mental health reforms in England, there are some important dilemmas still to be resolved. Some of these will now be discussed.

How can the stigma attached to mental illness be reduced?

Government statements on the failure of community care appeared, at least to some

commentators, to be a response to very negative media discussions of community care in the 1990s. A number of acts of violence by mentally ill individuals received extensive publicity, and were reported as indicating that caring for the severely mentally ill in the community is dangerous. This theme has remained dominant in reporting on mental health policy, despite substantial evidence that the rate of homicide by individuals with mental illness in the UK has not increased as deinstitutionalization has proceeded (14). Attitudes to mental illness among the public mirror this exaggerated concern. A large population survey indicated that attitudes to schizophrenia are especially negative, with many believing that individuals with schizophrenia are generally violent and unpredictable, as well as being hard to talk to. These views were more prevalent among people under 65 than among older people, and were widespread even among people whose factual knowledge about schizophrenia otherwise seemed reasonable. The Royal College of Psychiatrists has mounted a 5-year campaign aimed at challenging negative media reporting, increasing public understanding of mental health problems and reducing stigma and discrimination against the mentally ill (16). Currently this stigma is a central factor in the social exclusion which continues to be experienced by the severely mentally ill in England (17).

How can services respond effectively to mental health emergencies?

While community mental health teams often provide some emergency care, this has usually been in office hours only and has had to compete with the other responsibilities of team members. After 5 p.m. and at weekends, the major source of emergency help in many areas has been the local casualty department or a hospital-based emergency clinic, although a duty psychiatrist and social worker have generally been available to carry out assessments where there is a situation serious enough for immediate detention in hospital under the Mental Health Act to be considered. Groups representing service users and carers have often expressed the view that emergency intervention is not sufficiently accessible to them, especially out of normal working hours (18).

Service users and carers also often express a wish to receive treatment as far as possible in their own homes. Smyth and Houlst (19) have argued that lack of intensive home treatment services, such as the crisis resolution team described above,

has been a surprising gap in UK service development, especially in inner-city areas where demand for acute beds currently often outstrips supply. Government policy now stipulates that crisis resolution teams should be provided across the country to meet these demands for better access to emergency care and home treatment, with 335 such teams to be introduced by 2003.

The crisis resolution team has not, however, as yet found universal acceptance as the best way of providing emergency intervention. They have been criticized as disruptive to continuity of care, as patients' care is transferred to a different team just at the time when they are most unwell (20). The reliance on older studies as evidence for the effectiveness of these teams has also been criticized, as standard English community services now work with patients in community settings to a greater extent than the comparison services in earlier research studies (21). Burns also suggests that the crisis resolution team model is an artificial one, as deteriorations in the health of patients generally occur over some weeks or months rather than abruptly in the middle of the night: thus the aim of good community services should be crisis prevention rather than crisis resolution. An alternative to the crisis resolution team may be the enhanced community mental health team, in which availability of more workers might allow sector teams to provide an extended-hours emergency service and more intensive home treatment.

How can services manage difficult to engage patients?

While standard community mental health teams appear able to keep in contact with and monitor most people with severe mental illnesses, a minority remain very difficult to engage. These tend especially to be younger people who have generally chaotic lives and poor social support, may have a history of offending and comorbid substance misuse, and often feel that conventional services and social institutions have little to offer them (22). They are heavy users of in-patient services, often on a compulsory basis. Assertive outreach teams of the type recently established in Islington are now proposed as the most appropriate way of trying to meet the needs of this group and prevent them from spending long periods in hospital or engaging in acts of violence. Many areas have very recently established such teams, and the NHS Plan (2) states that they should be available throughout the country by 2003. As with crisis resolution teams, there continues to be some debate about the

appropriateness of this model for the UK (23). This debate has focused especially on the lack of evidence that teams with low case-loads have produced better outcomes in research evaluations in the UK. This view has been met with the argument that most of the intensive community services evaluated in the UK have not adhered closely to the Assertive Community Treatment model, even though this is the form of care for the difficult to engage for which there is most supporting evidence from research carried out in other countries (24).

Many difficult-to-engage patients have comorbid substance misuse, and treatment of 'dual diagnosis' of substance misuse and severe mental illness is also currently receiving considerable attention in England (25). Additional training for generic mental health staff in working with substance misusers is a strategy favoured in many areas, but little evidence is so far available as to the best way of incorporating interventions for dual diagnosis into NHS services.

Does effective community care require a community treatment order?

Within the mental health professions, the move towards increasingly intensive community-based treatment has fuelled a heated debate about whether it should be possible to administer medication compulsorily without admission to hospital. Outside the professions, public and media anxieties about violence among the mentally ill have created a favourable climate of opinion for the introduction of a compulsory community treatment law. Plans for the forthcoming revision of the Mental Health Act indicate that new legislation will allow compulsory administration of medication in the community (26). A further proposal for this new legislation is that it should include powers to detain compulsorily in hospital individuals with severe personality disorder who appear to present a risk, even where they do not meet the previously applied criterion that their psychiatric disorder should be treatable. This has excited considerable controversy, and a widespread view among service users and mental health professionals is that this power is both ethically contentious and likely to be very difficult to implement in practice (27).

How can high quality staff be recruited and maintained in mental health services?

A difficulty frequently undermining attempts to deliver high quality care and develop innovative

services is that in many areas there are shortages of qualified mental health staff of all professions (28). Most mental health services are trying constantly to recruit qualified professionals, and staff retention is also a central difficulty in many areas. This difficulty is likely to become more acute as the several hundred new crisis resolution teams and assertive outreach teams currently planned are established (2). High staff turnover also often prevents multidisciplinary teams becoming fully established and functioning, as staff including team leaders often leave their posts after relatively short periods. There is evidence that levels of 'burnout' in staff are high (28), and concerns have also been expressed that new service models involving intensive community working with patients who present a risk of harm to self or others, such as assertive outreach and crisis resolution teams, may be especially likely to be associated with high levels of staff burnout. Evidence allowing this suggestion to be evaluated adequately is not as yet available, but certainly these service models are unlikely to succeed unless skilled and motivated staff can be recruited. The recent prominence of these concerns about the mental health workforce has made development and implementation of better strategies for staff training, support and retention major priorities in both the National Service Framework for Mental Health (1) and the NHS Plan (2).

As discussed above, suicides and, in particular, homicides by psychiatric patients are often reported in the media, and staff may be named in the press following a serious adverse incident involving a patient in whose care they are involved. Their names may appear in national newspapers after the event or some time later when a public inquiry report on the event has been published (29). Fear of being publicly pilloried in this way following homicides and suicides may lead staff to focus more on assessment and containment of risk than on achieving therapeutic change. Priebe (30) has commented on the consequent development in the NHS of a 'blame culture' characterized by anxiety and defensiveness.

How can mental health interventions in primary care be made more effective?

Most mental health problems in the UK continue to be managed in primary care, including the great majority of people with depression and anxiety disorders. There has also been much discussion about ways of developing shared care

between primary and secondary care for severely mentally ill individuals. Full discussion of this complex area is outside the scope of this paper, but debates continue about the best way to reduce the large variations which currently exist in GPs' skills in identifying and treating mental illness and in treatments available in primary care (31) and about the most effective ways of increasing integration between primary care and specialist mental health services (32). One of the interventions proposed in the recent NHS Plan (2) is the introduction across the country of a thousand graduate primary mental health care workers with training in brief therapy methods.

Conclusion

Now that closure of the large asylums has largely been accomplished and a network of community mental health teams is in place, England is entering its next phase of community care development. Vigorous attempts are being made to fill the gaps and resolve the problems still identified. Since England has a national health system, central decisions can be taken and new policies issued frequently, but implementation of these policies may none the less prove problematic. A critical determinant of the success of current initiatives is likely to be the outcome of attempts to improve recruitment, retention and morale of mental health professionals.

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