

Mental Health Reform in England*

Professor Louis Appleby

National Director for Mental Health, England
Professor of Psychiatry, University of Manchester

It's a great honour to deliver this memorial lecture in memory of Dr. Gerald Choa. I hope he would have approved of the reforms we have put in place in England, which are primarily about extending community services beyond their traditional role. My task is to describe to you a period of recent reform of mental health care, the last ten years of mental health services in England. I am a clinician and an academic psychiatrist. I was asked to come and work with the Government in London as they set about reforming the National Health Service. My job is not to become a politician or a civil servant but to provide clinical advice on the development of national policy and putting that policy into practice.

What happened in England in the last ten years is a kind of case study which I hope other people can learn from. Many things about the reform process have gone well, a few have gone badly, and many people have contributed. We do not think that in some sense we have the answer to reforming mental health services wherever you are in the world. This is just our experience and we certainly have had an interesting time. I can honestly say that this has been the most fascinating, the most frustrating and the most rewarding period of my career.

National Service Framework for Mental Health

This is actually a picture of the Big Bang in mental health, not the Big Bang in the

universe. This is how it all began for us. The recent reform of mental health services, starting in 1999, with a Government document called the National Service Framework for Mental Health. This document was a policy blueprint. Essentially it was a description of how services should be organized wherever you lived in the country, the country being England. Strangely enough, Scotland, Wales, and Northern Ireland have different mental health policies, but this is England. This is a blueprint for mental health care throughout the country as specifically about working age adults.

The National Service Framework for Mental Health was the first of the National Service Frameworks (NSFs) that the Government published. That in itself was a very important message to the service, about the priority that mental health care deserved. NSFs thereafter have been published in a number of different health specialties. It was built around seven standards. These standards are essentially aims for the service. Quite broadly based, two standards were about severe mental illness and its treatment. There were two that were about primary care and access to services. One was about promoting mental health. One was about the welfare of carers, and one was about preventing suicide. There were also commitments on research, commitments on information and their investment. Essentially these standards have formed the basis of everything about national policy in the subsequent nine and a half years.

*Transcript of the presentation at the 4th Dr. Gerald Choa Memorial Lecture of the Mental Health Association of Hong Kong delivered on 7th January 2009.

Community Care Reform

Back in 1999 when this document was published, community care was seen in England as a failed policy. In fact the Secretary of State for Health famously said in a speech

When I was a clinician and as a clinician I've been subjected to the opinions of many clinicians who were my colleagues, every now and then they stop me in the car park and they say, "what we want is..." and then they tell me what they want. And very often what they want is more beds. I have a colleague whom I worked with for many years who used to see me parking my car in the car park in the hospital where I worked and he would walk past me and he would say, "more beds". That's all he said to me for about two years, "more beds".

There was an unambiguous message from clinicians – "We want more beds". What they meant was that the pressure on the care system had become too great and the way that he felt that pressure as a clinician was in providing acute services. There are two things you can do about that. You can build more beds, in which case they will be full soon as well or you can strengthen your community services to try to take the pressure off the acute system. So what we have tried to do is to strengthen community services to take the pressure off acute care. You

When the politicians said to me, "What could we do to improve community services?" I thought it was not a good answer to say we should do a bit more than what we do at the moment. What we needed to do was something different. Politicians always need a new initiative, as part of their job is to present new ideas to the public. There's no point in debating it or disputing it. That's their job and so you've got to help them do their job.

Our concerns were first of all about those patients who were severely mentally ill with complex needs, both clinical and social needs, who would drift out of services. Because of illness they would find it hard to accept what services would offer and they would drift away, so they would be more at risk and more vulnerable. So we wanted to develop a service which would support those patients and prevent them from deteriorating and needing multiple re-admissions, so-called 'revolving door patients'.

We designed Assertive Outreach services, intensive, community-based, small patient caseload,

that community care had failed. That came as a great surprise to those of us who thought that it had never been tried. Our job since then has been to try to deliver community care as it is intended. The greatest theme of our reforms has been to strengthen community care.

have to remember at this time that community care has lost a certain amount of not just political confidence but public confidence. There had been a series of highly publicized incidents in which a mentally ill person living in the community had attacked a member of the public sometimes with fatal consequences. That then led the public to believe that community care was a euphemism for poor care, care that was underdeveloped and under-resourced, so we have to present a new model to the public, to politicians and to clinicians, a new model of community services.

and we set a target nationally of 220 Assertive Outreach Teams for the whole country. We wanted to directly take the pressure off beds. We were conscious of the fact that clinicians felt beds were under too much pressure and there was no alternative. So we developed what we called Crisis Resolution services, providing home treatment as an alternative to admission when that's a safe and acceptable alternative. We set another target - 335 Crisis Resolution Teams across the country. We were concerned too about young people becoming ill for the first time, developing their first episode of psychosis, very often their first experience of schizophrenia, who the evidence showed would

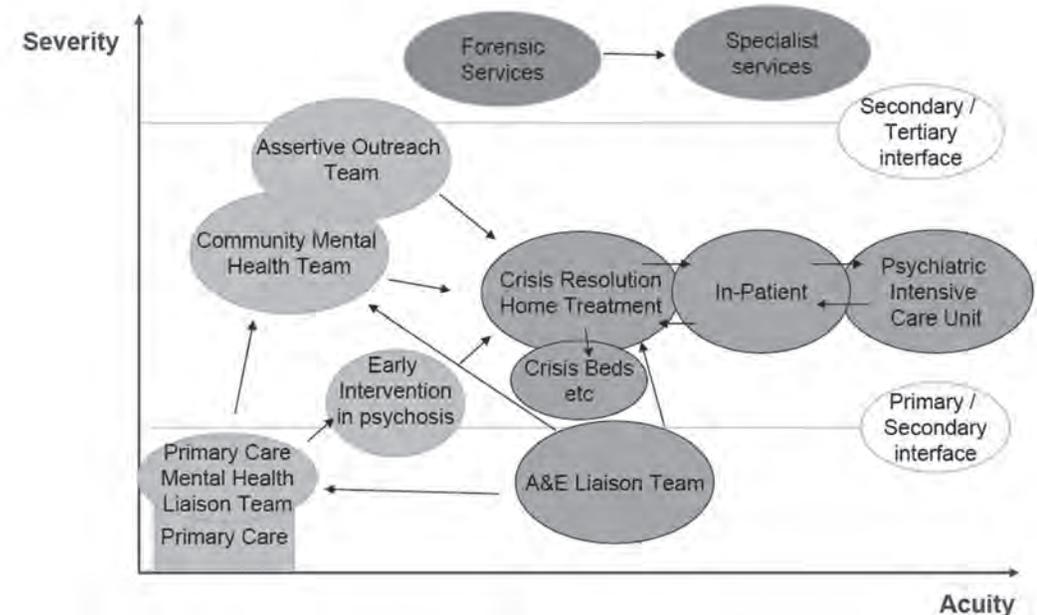
wait several months, sometimes a year, sometimes 18 months before their first contact with the services that would provide them with treatment. We wanted to treat them earlier and so we devised a new service, Early Intervention Teams for young people with psychosis, working with clinical and social services, working together with other agencies like employment and educational support, working to support families as well. The target was 50 Early Intervention Teams for the whole country.

Of the many reforms of community care, this was the core of our reform process using a set of targets, attaching them with to the conspicuous weak points of what community services had previously offered. We were trying to develop a more specialised model of community services (Fig. 1). Crisis Resolution linked to in-patient

services, a new way of providing acute care. Early Intervention services, the first contact for some people becoming ill and assertive outreach for those patients who may become ill and may end up needing forensic services. For existing community mental health teams it might mean that some of their work would be squeezed by assertive outreach and so their role might be diminished. But they might provide long term care for people whose risks are less, whose vulnerability is less. For some community mental health teams it meant working more closely with primary care, so moving more towards primary care and away from severe mental illness. This constitutes a specialised model of community care. In the end this represents a fantastic effort by frontline NHS staff picking up on Government policy and turning it into something real in local medical services.

I once had a member of services who came to me and said, "where we work, it's just a little bit different. We need a slightly different service from the national policy". Believe me, everybody works in a service which is slightly different. There's no service which is not slightly different. You have to be prepared to say, "Well, I'm sorry. That difference doesn't matter. You have to do what national policy says."

Fig. 1. NHS Plan: new community teams



When you are asked to devise policy, the second worst thing that can happen to you is that you can get the policy wrong. The worst thing that can happen to you is to get the policy right and then nothing changes. You cannot change services from central Government. You can change policy, but in the end you have to sell that policy to frontline staff in a way that makes them want to change their local services. This was performance managed. In other words, it was my job to be rigid and inflexible and to refuse to change the targets in line with what local people wanted. One of the

criticisms that national policy came under was that people said, "Is there enough research evidence done to back up these changes? This is a very new way of doing things." The honest answer is "No. There isn't enough research evidence if by 'enough' you mean gold standard, numerous clinical trials, all showing the same thing." There wasn't that amount of evidence. But what we did have was sufficient evidence to make changes. We have evaluated each of these services in a big programme of evaluation for each of the services I have described.

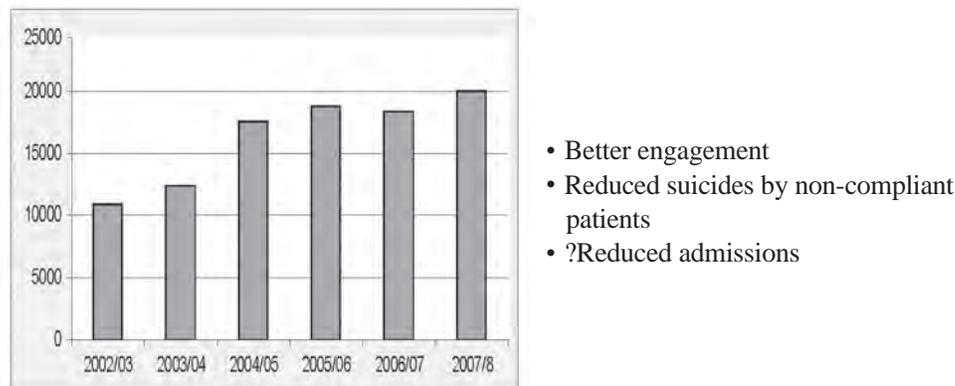
If politicians come to you and say, "We want to make some changes. What do you think?" You can't say, "Well, what I think is that we need a 10-year research programme until we've worked out the answer to service reform". You have to say, "Well, on the basis of current evidence, here's what I think we can justify". So you need change on the basis of the best evidence available not the best evidence possible. That's an important point because clinicians will always say to you, "We want to develop evidence-based service", and you have to say, "This is the best available evidence". If you do that, there's an important part of the deal with services that you have to fulfill. That is, you have to be prepared to evaluate the service as you change it.

Programme Evaluation

What has happened - not the number of teams but the number of patients treated. 20,000 people now treated by Assertive Outreach. Our national evaluation showed that this previously disengaged group of patients is now better engaged with the service. The number of suicides by patients who are refusing treatment has gone down.

In the early years, the evidence of reduced admissions was doubtful. It looked as if we had forged a better relationship with patients but as yet to reduce the reliance on in-patient beds. The evidence coming through now is changing (Fig. 2). An important theme is that sometimes you need to allow services to bed into a system before you can get the full benefits. Sometimes those benefits are observable in a local service before they are detectable nationally.

Fig. 2. People served by assertive outreach teams



There is a service which I just happened to visit about six weeks ago in South Staffordshire in the Midlands of England. It's taking their revolving-door patients for the three years before they introduced the service and the three years after. In that group of people, the people who are now receiving the service, describing their care before the service began and after it began. What this is showing is that within that group the number of admissions has almost halved, and the number of admissions under the Mental Health Act, compulsory admissions, has almost halved, and the number of occupied bed days, a very important economic measure, has almost halved.

What we wanted to do was to reduce reliance on in-patient beds. The number of admissions to mental health units during the time for working age adults has reduced gradually. There has been a small reduction in the number of beds as well, but the number of admissions has gone down more than the number of beds. That's particularly true in the last two or three years. This period here corresponds to the time when the new home treatment teams have come into place hence reduced reliance on in-patient beds.

A look at crisis resolution - now over 100,000 people a year are treated by crisis resolution (Fig. 3). An independent organization in England called the National Audit Office, responsible for detecting waste of public money, did a study of crisis resolution to see if it was worth the money. They produced a very favourable report which showed it was reducing admissions and improving patients' satisfaction, but they also said it would work much better if psychiatrists were part of the crisis resolution service. It added that the crisis resolution team occupied a position as the gatekeeper of all admissions. So for everybody who needed to come into hospital, it suggested that the first step was an assessment by a crisis resolution professional led by a psychiatrist, to decide whether admission was necessary or if home treatment could be indicated.

What about early intervention? This is the number of people treated by early intervention services. These are the young people becoming ill for the first time. This corresponds epidemiologically to about 8000 new cases of schizophrenia per year. The national evaluation has shown that admissions are being reduced, that patients are more likely to be in employment in the new service, and the patients like it. One of our leading early patient intervention services is in Worcestershire - here is what we knew about the national experience for young people with schizophrenia. The duration of untreated psychosis - the time from first symptom to first treatment - has been reduced. There's been a reduction in reliance on admission and re-admission. Engagement with the service is much better, families are happier, and the social outcomes measured by employment are much better (Fig. 4).

Fig. 3. People served by crisis resolution teams

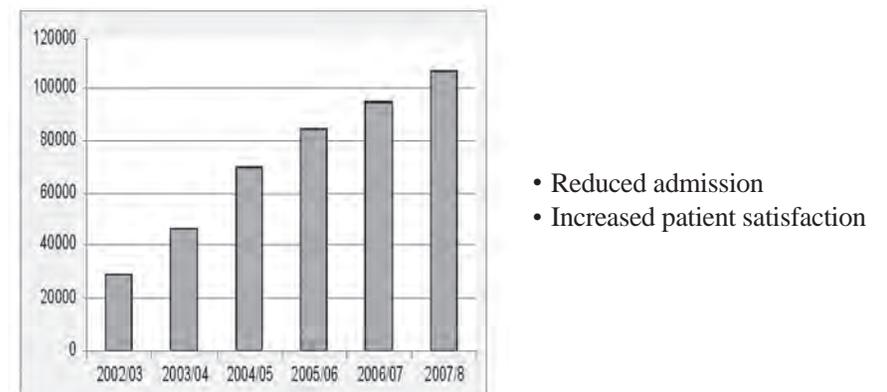
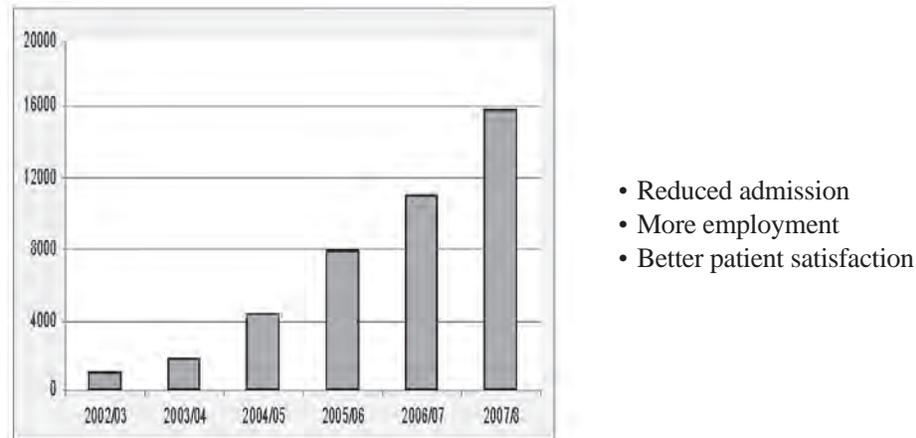


Fig. 4. People served by early intervention teams



Investing Mental Health

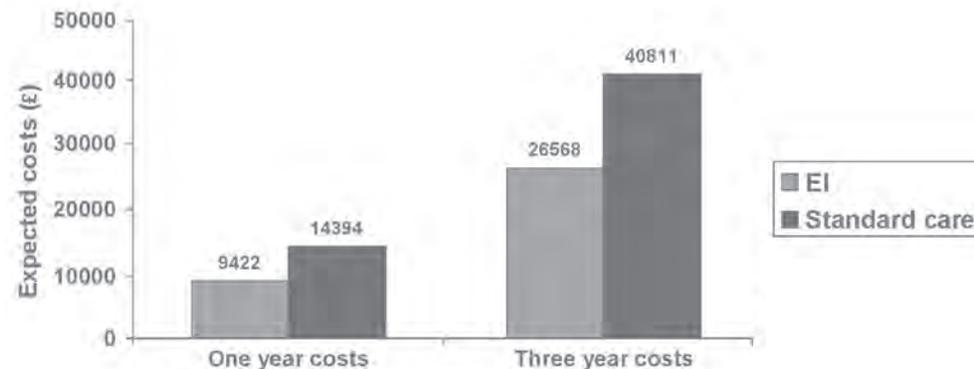
There's an economic evaluation of early intervention (EI). The first results from that economic evaluation is that the average cost of care per patient at one year and at three years the cost of care is reduced by about a third (Fig. 5).

What about this reduction in the cost of admission? You might say that reducing costs, that money goes somewhere else and the money is lost in the system. That doesn't seem to have happened in mental health. The

investment in mental health services nationally during the period of community care reform represents a rise in investment of about two billion pounds per year, against our 1999 baseline, which is about 3 1/2 billion, to about 5 1/2 billion pounds per year nationally. That's not counting drug costs. It's not counting capital costs. This is how much we spent on the service, taking us to about 170 pounds per adult for every adult in the country.

The question then is how much of this money was earmarked or protected or ring-fenced by the Government of that two billion?

Fig. 5. EI Cost Economic Data



And the answer is 75 million pounds, just under 4%. 96% of the increased two billion was spent even though it wasn't protected money. This is a very important issue about reform. Services responded to Government priority in the Government plan by realizing that mental health services had to be invested in. In mental

health in England, people felt for a long time that unless there was money up front in the service, it would never be available for services. In fact, what we discovered was that setting the priorities and setting the plan drives the investment. You have to have the plan for what that money is for and that will drive the money.

I think it was a brave decision for the Government to say that even though there was no clamour for better mental health care, we are going to make it a priority. They accepted the arguments. I think they deserve a lot of credit. Sometimes there's frustration. Of the three or four priorities, we're probably number three or four rather than number one.

Staff is our biggest resource in mental health. To give you an example, there is an increase in consultant psychiatrists of about 45% over that period of time. When I came out of my own service and started to work for the Government, one in every seven consultant psychiatry posts in England was vacant. There was a serious staff shortage. The previous governments had invested in medical student training and so we were getting more doctors coming through the system. We were able to attract many of them into psychiatry and so a big increase occurred. More resources were being spent on psychiatrists and others. There was a similar but slightly smaller increase in the number of mental health nurses. There the increase was about 22%.

My reform of community care meant new services, new teams, more money, more staff, but it also meant doing something more for carers (Standard 6 of the National Service Framework). We had a target to employ 700 carer support workers, people who would provide specific support to the families of people with mental illness. That target was much more difficult to achieve and it was eventually achieved. Carer services improved, although they improved in a slightly faltering and patchy way across the country. If you look at what local services did, on the south coast of England, in Brighton, they spent carer money on providing dedicated staff who were there to give information and support to families and to provide respite care

for unsupported families to allow the patient to spend time in hospital, giving a break to family carers. In a different part of the country near Bristol, in Avon, they spent their money on something different. They were providing a therapeutic intervention for the families, working directly with them, reducing expressed emotion. They also invited carers to take part in training, in research and in the management of the service. So it was a very different approach. What carers had was different in different parts of the country.

Patient Experiences

You're probably asking, "Well, that's all very well, but what about the patients? What did they say about this new service?" The government set up an independent body called the Health Care Commission, which acted as inspectorate and it carried out surveys about the quality of the care. One of the surveys was a national patient survey of mental health patients living in the community. This is the question: "What do you think of your service overall?" You can see that the majority of people think that they are getting good service, or very good service or even an excellent service (Fig. 6). 8% of patients think their service is poor or very poor. Obviously 8% is too many. Sometimes if you read the press in England, they are very critical about mental health services and they present a picture of mental health services which is uniformly bleak and in crisis. They

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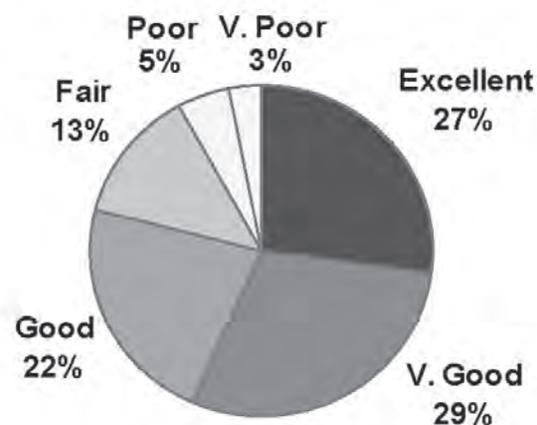
use that phrase all the time, that mental health services are in crisis. But in fact if you ask the patients, they don't say the service is in crisis. Generally they're pretty positive, but some are critical. If you ask a slightly different question and ask patients about the staff, "How did you feel about the people who provided care?" The responses are much more positive, at least reasonably positive, but they're very positive about staff. Patients feel listened to, they feel treated with respect and dignity. They're very positive about psychiatrists, are particularly positive about nursing staff.

I have talked about strengthening community services in order to take the pressure off acute care. If your system is under pressure, if your acute beds are under too much pressure, you will probably use the Mental Health Act more.

I want you to accept that admissions under the Mental Health Act are an indirect reflection of the pressure that your acute services are under. In England during the 1990s we had quite a steady rise in the use of the Mental Health Act reflecting what that passionate psychiatrist in the car park was talking about. Since this period of reform began, there has been no significant increase in the use of the Mental Health Act. Whether that is because of changes to community care, we don't know, but certainly by that measure of pressure, the service has – even if it isn't getting better, it's stopped getting worse. We have a new Mental Health Act in England, started two months ago, which introduced compulsory powers for community treatment so this information may change further. We need compulsory powers of community treatment to back up the reform of services.

I believe as a clinician that live in a humane society we have a responsibility to people when they are ill and at their most vulnerable and most risky, to do the right thing for those people even when they are refusing what we have to offer. I think if you accept that, then the mental health legislation has a humane purpose, a therapeutic purpose. It is about bringing people treatment when they would otherwise go untreated. We've introduced in England is a community treatment order, which allows me as a clinician to bring treatment to people by law which they would otherwise refuse and as a result become ill and at risk. I know that's a controversial thing to do but I think it is the humane thing. The community treatment order brings with it a lot of other things. It brings entitlements to proper care. It brings better outcomes. It brings what patients really want, which is to get their lives back together and live more stable, more positive lives. As professionals we have to be prepared to argue it that way and take the criticisms.

Fig. 6. Rating of care received from mental health services in the last 12 months



Mental Health Reform in England

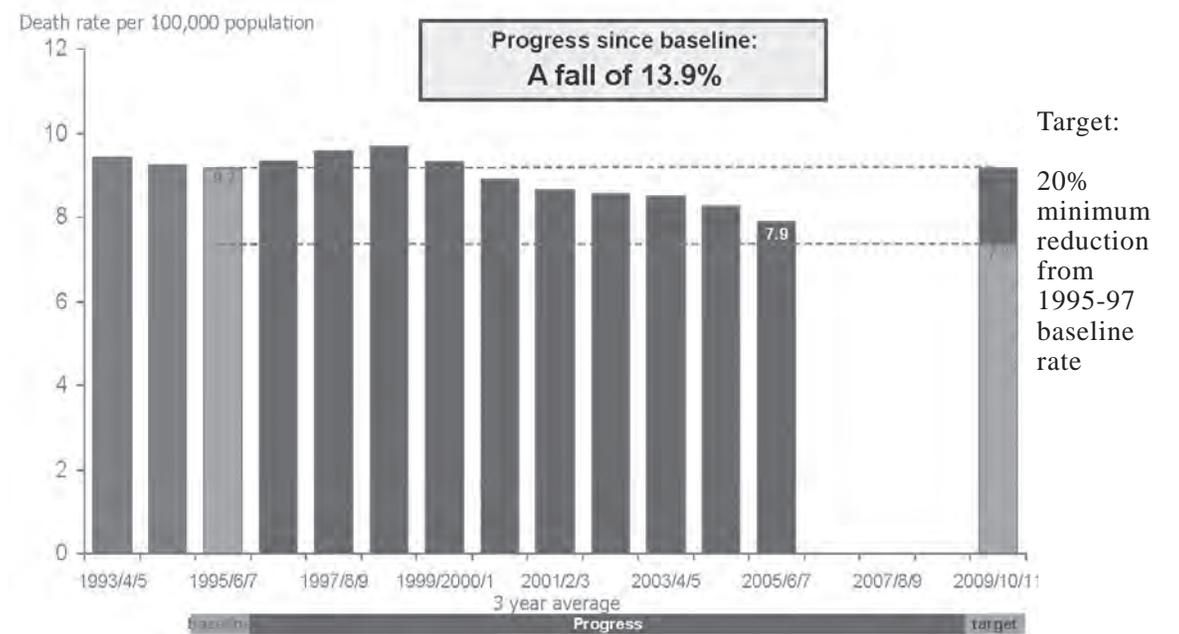
The above mentioned is my number one favourite change to mental health services: the changes to community care, driving investment, driving changes, including better patient satisfaction and more support to carers.

Suicide Prevention

Number two favourite for me is suicide prevention. In 1997, before the national service framework, the government set a target to reduce suicide in England by 20% by 2010. It went up a little bit and now it's coming down. Overall the fall is about 14%. That's about 500 fewer deaths per year in England. Now we have a suicide rate which has fallen below eight per 100,000 people per year for the first time (Fig. 7). This is the lowest figure that we've ever had in

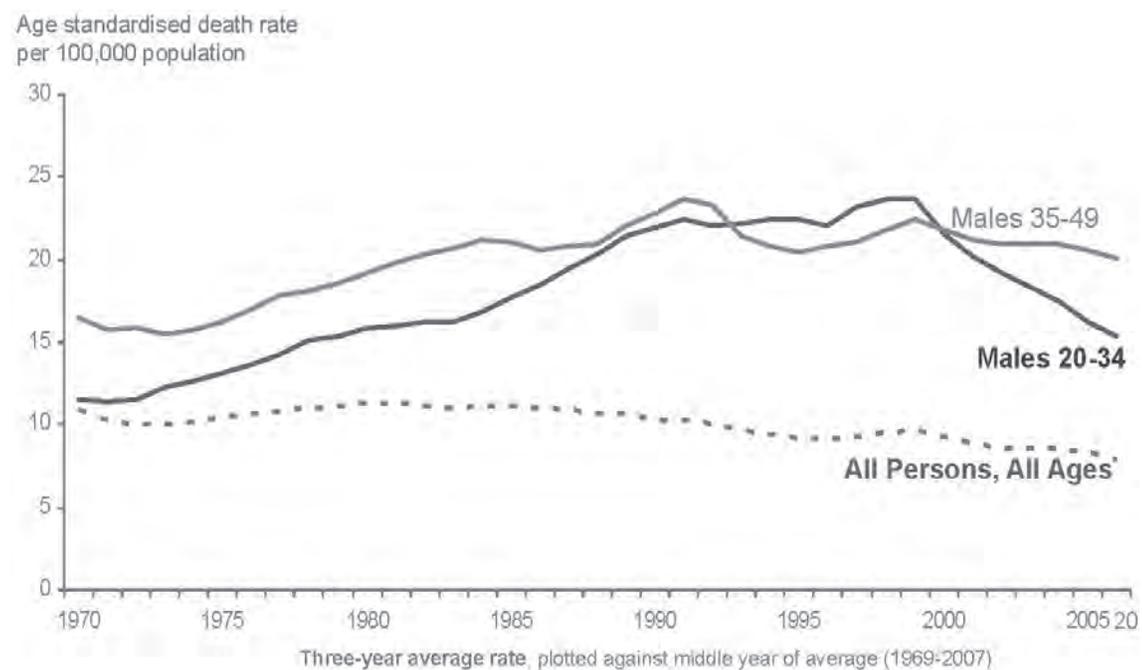
England and our records began in 1861. In England we had an epidemic of young male suicide, men under the age of 35. From the early 1970s the suicide rate more or less doubled (Fig. 8). Part of reducing suicide has been to try to reverse this rise. Since the National Service Framework year, the suicide rate has fallen year by year, seven consecutive years. I suppose the question is, "Why?" I think it is partly that frontline services are much more aware of the risk that troubled young men face and there have been specific initiatives. I think it is also that the economic circumstances have been favourable in England. When unemployment rates are low, suicide rates are also low. Suicide rates also can't be relied on to go so well. There is a sting in the tail for many of these findings.

Fig. 7. Death rates from Intentional Self-harm and Injury of Undetermined Intent in England 1993-2007



Rates are calculated using the European Standard Population to take account of differences in age structure.

Fig. 8. Trend in suicide rate for young men (aged 20-34) and men (aged 35-49)



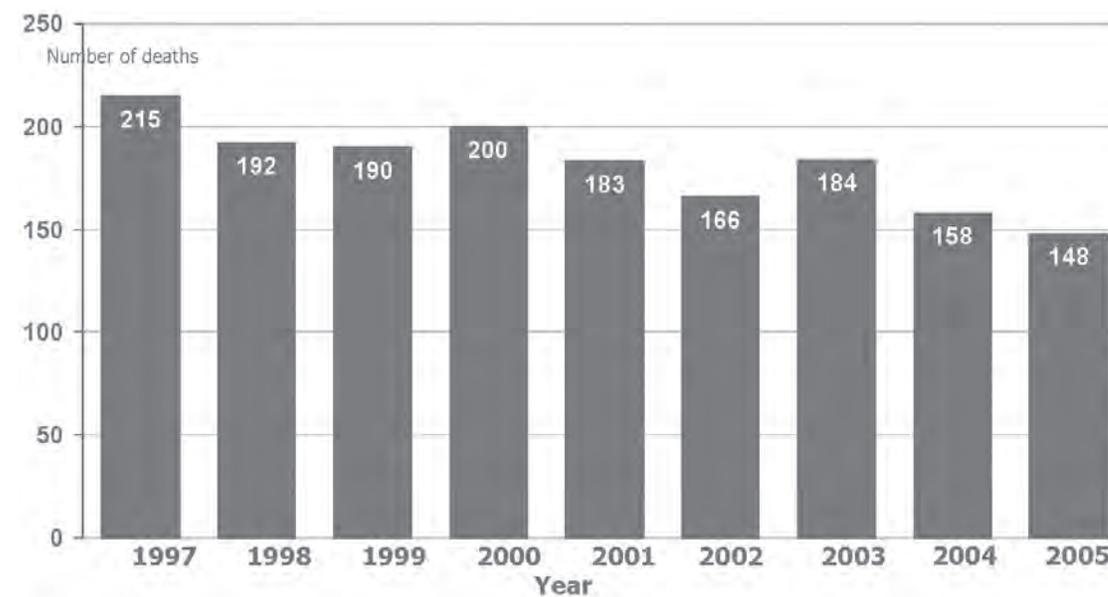
Rates are calculated using population estimates based on 2001 census. Rates are calculated using the European Standard Population to take account of differences in age structure.

Years to 1998 and 2000 have been coded using ICD9; 1999 and 2001 onwards are coded using ICD10.

The number of in-patient suicides in England during the period had a fall of about 70 deaths a year, and the national figure has gone down by about 15% (Fig. 9). The number of deaths among in-patients has gone down by about 30%. The question again is, "Why?" It isn't because of a reduction in beds. No matter how you calculate it, this is a reduction in rates and numbers. In 2000 the service had collected data over these years. We discovered that the majority of the main method of suicide among in-patients was by hanging on wards. It's a rather grim reflection on life on in-patient care.

They were hanging themselves from non-collapsible curtain rails, rails around the beds, rails around the showers. This seemed to be particularly scandalous because there were collapsible alternatives available, commercially available railings which were not weight-bearing. So we wrote to every hospital in the country and said that we want you to remove all your non-collapsible curtain rails and replace them with collapsible rails in 2000. Since then the figures have come down but only about half of this fall was of people who were hanging themselves on wards from curtain rails.

Fig. 9. In-patient suicides, persons



England 1997-2005*

* Includes projected figures to account for incomplete data

* Projected figures are shown to provide the most accurate number of cases expected for the given time period

* Projected figures may vary annually according to changes in the baseline data

[^] Note: Data for 2004 are 94 percent complete.

This is another important theme of this talk, if you get the right central measure, then a lot of other things will happen as well. What's happened on in-patient wards is that people have not only removed the curtain rails, but they also thought more about safety. There has been a general improvement in ward safety as well as a reduction in in-patient harm. If people thought about mental health more, they invested more in general. There has been a general improvement in ward safety. So my second favourite reform – suicide prevention.

Modern Treatments

Number three for me is the introduction of modern treatments, the use of atypical antipsychotic drugs in England. When I was working in the clinical service, if I wanted

to prescribe atypical antipsychotic drugs for schizophrenia, I had to write to the health authority for permission. They were rationed and kept. We now see a very large rise in the use of these atypical drugs. This is something like a twelve-fold rise in the use of the drugs, so they are far more often used now. This is a volume indicator of prescriptions far more commonly prescribed than the older drugs. The question is, "Why has that happened?" It isn't because these drugs are more effective with the exception probably of clozapine. They're not more effective, but they are preferred by patients because of their side effect profile. This is a reflection of patient's choice, of giving patients a say in treatment decisions, which they have expressed by asking for modern treatments. It's a reflection of clinicians responding to patient's choice, by saying that yes, if that's the drug you prefer, we'll prescribe them.

In any group of professionals there are some people who are resistant to change. They're good people, not bad people, but they feel threatened by change. You have to take those people with you because you rely on them to deliver a service. You cannot just transform a service overnight by Government requirement. You have to publish, persuade, give lots of talks, develop the evidence, feedback – it just does take time to change services. In the early years, the first two or three years, the greatest difficulty, a big obstacle for me, was just the pace of change.

How do you change clinicians' behaviour? Well, the Government set up another organization called NICE, the National Institute for Health and Clinical Excellence. They produce clinical guidance to the system on the basis of research evidence. They will assess the cost effectiveness of a treatment like atypical antipsychotic drugs, and look at all the treatments that are available for a clinical disorder like schizophrenia, and they will publish guidance to clinicians as to how they should treat it. NICE helped us by publishing guidance on schizophrenia which said that atypical antipsychotic drugs should no longer be held in reserve; they should be considered as firstline drugs. So number three of my favourite change: modern treatments.

Safer Inpatient Environment

On the 1st of July 2008, by law, it is illegal now in England to allow smoking on mental health wards. This took quite a lot of persuasion by government ministers to do this. The British Government introduced smoke-free legislation which applies to work-places, to many public places, in July 2007, and the NHS was included and went smoke-free on the 1st of July 2007. Initially the plan was that mental health wards would be given an exemption as they had been given in other countries. But we persuaded ministers that this was the wrong message about the physical

health of people whose primary problem was mental ill health, and all that was needed was an extra year for mental health wards to get smoke-free facilities in place. So on the 1st of July 2008, all mental health wards went smoke-free in England. This is partly because we want to improve the physical health of patients. Patients in England smoke more than the public and they have a higher rate of smoke-related disease. My first job in mental health was, in my holidays as a medical student, in an asylum as a nursing assistant, and part of my job was to hand out cigarettes. Now wards in England are smoke-free. The smoking culture has gone. It is about providing a better physical environment, safer, but also a better therapeutic environment for fit patients. It is also about improving the status of in-patient care despite the developments in the community.

I think we can say that although at times in-patient care remains a troubled part of the service, we've seen a fall in suicide. We've seen a move toward single rooms. That is how most of the units, incidentally, got rid of their curtain rails. There is no need for curtain rails if your patients are in single rooms. Most of the wards now are required to be single sex accommodation so women are protected from ill patients because they are cared for in female-only environments. A great deal of money has been spent building

new wards. There is an example of a ward in England which I opened a couple of months ago, in Crawley, Sussex. This a model of a modern ward, deliberately designed, partly designed by patients, partly designed by staff. There are many architects now who specialise in the design of modern wards.

What Next?

Our task in England now is to extend reform into society as a whole, to the mental health care of society more broadly to address the mental health needs of the community as a whole, addressing the social causes, the social consequences of mental disorder.

First of all, we have to improve psychological therapies. Patient's choice of service in England shows that what patients really want is access to psychological therapies if that's a safe alternative to drug treatment. Nothing wrong with drug treatment but patients on the whole prefer non-drug therapies. The Government has accepted this argument and has allocated new money, 173 million pounds a year for the development of new therapists, 3600 new psychological therapists to deliver primarily aided therapy.

There had been a huge rise in the number of clinical psychologists in England, a 70% increase in the number of clinical psychologists, the people who deliver CBT. And yet the waiting lists are still several months and in some cases a year or more, far longer than the average duration of a depressive illness. It doesn't make sense to keep people waiting that amount of time. So if you want to improve the availability of therapists, you have to have more people but you also have to do other things.

You have to link therapy to social outcomes, so our services link therapy to helping people back into work or staying in work. You have to reform the care, and again we had help from NICE in developing a model of service. When bring in for all those people who are suffering from depression, you have to have more self-help. We've introduced computerized self-help, which should be available now in every part of the country.

Secondly, employment is an important theme for us for mental health in England. We are trying to improve the employment prospects of people with mental illness, and the report on "Mental Health and Social Exclusion" published in 2004 was very important. What they pointed out was that the majority of people with severe mental illness are not employed, even though they could be. It pointed out that there were two and a half million people living with incapacity benefit, and 40% of them were on that because of mental health problems. It pointed out the stigma, which is one of the biggest obstacles of getting people with mental illness back into work. 60% of employers in this Government survey said that they wouldn't employ somebody with mental health problems. The story is that mental health costs the country a lot of money. It's estimated it costs England about 77 billion pounds per year, much of that is in employment and related costs.

Again, it's the local services which can make a difference. This is a service in London which has developed an employment service for people with severe mental illness, based on Individual Placement and Support. It's essentially a personal vocational support for individuals. In these patients with severe mental illness, employment has increased through this

vocational support from 10% of patients to 40%. If you define vocational outcomes more broadly to include education and training, the numbers go up from 45% to 90%. Almost all patients get in some kind of gainful vocational activities. Patients can work. They can be educated and trained if we provide the opportunities. It's not enough for us to tell employers what to do. This trust has involved employers. They employed 100 patients, and they not only kept those patients in employment, but they demonstrated savings of about 32,000 pounds per patient per year. This was in reduced treatment costs and in reduced welfare payments. Also, because these patients were earning money, they were paying taxes. Once you're earning money, you put money back into the system.

Thirdly, there is a need to improve services for ethnic minorities. In Britain we have a culturally-diverse community now. The evidence is that psychosis is much more common in some ethnic minorities, not just in Britain but in most parts of the world. The reason for this is something to do with the migrant and minority experience of people

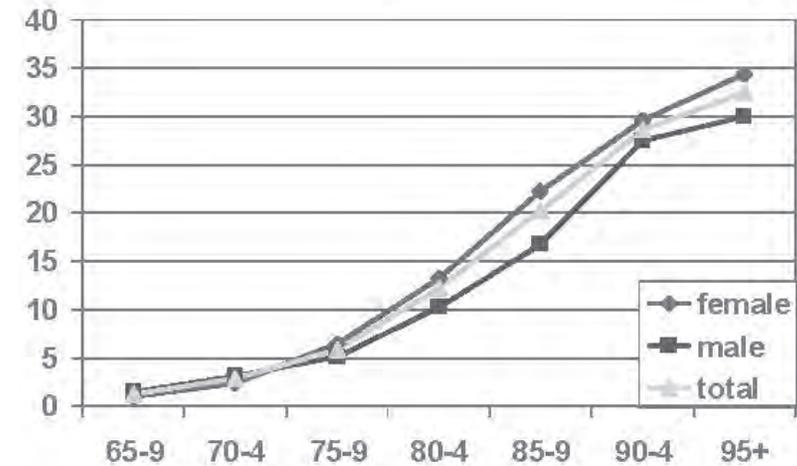
living in a host country – urban poverty, poor education, poor employment prospects. Those kinds of social adversities make people ill. People get ill when they are treated unfairly. In the service we perpetuate these problems. For example, of what the service offers, only 14% of our patients from ethnic minorities are offered psycho-therapies. That's about one-third of what we offer the indigenous white population. Ethnic minorities perceive - it may not be true - but they perceive discrimination in the service, particularly on our in-patient wards. So we have a serious problem of trust, a serious problem of winning the confidence of migrant minority communities. Our message has to be a positive one of equality. If people are in an unequal position in society and you offer them the same service, then you perpetuate the inequalities. You have to do more for unequal people. Doing more means reaching out into their communities, providing them with unconventional ways of treatment, in this case whole treatment, which is becoming more conventional now in England. In a local service in Sheffield, improvements are greater in ethnic minority patients than they are in the indigenous population. So we can do more for our minority groups.

Social care is at the heart of much of what we have reformed about mental health care. It is partly a clinical reform but it is also about improving people's quality of life. One thing which we have encouraged services to do is to measure their success not just by length of stay but also by how many patients are in employment, how many patients have decent housing. Social inclusion is a cross-government target to improve employment and improve settled accommodation, particularly for some groups – people with learning disabilities, people with mental health problems and people who are already homeless.

Finally, our fourth priority for the future is dementia care. As the age of the population increases, more people are suffering from dementia. Over the next 30 years in England we expect the number of people suffering dementia to double, and the cost of treating their dementia to triple (Fig. 10). This is probably the biggest health and social care challenge that we face in England strategy about to be published. A

local service in Croydon in south London improves quality of life for people with early dementia. It reduces behavioural disturbance. It improves the number of people who are getting access to the service, and it reduces admissions to care homes. If you live in a very idealistic world where all of that money from reduced admissions is translated into the service, it would release an enormous amount of money for other forms of care.

Fig. 10. Population prevalence (%) of dementia by age



Conclusion

That's our reform, and what have we learned? We've learned that the service doesn't change by Government decree alone, you have to do something else to make sure that clinical services are transformed. First of all you need political priority. You can do nothing without political priority. Secondly, you need a national strategy like our NSF with broad support from patients and from professionals. You need resources, of course, but you must not let the lack of resources stand in the way because reform will drive resources. You need critical models, like the models that NICE published. You need a system for monitoring change, like the health care commission provides us, for example the surveys of patient satisfaction. In the end you have to reform the workforce. None of this can be delivered unless people work differently. You need new people. You need more people. You need new skills.

You need new ways of working. If you have all of those things lined up, then you have a combination that is vital for a modern service, high quality clinical care and skilled professions.

摘要

英國精神健康改革

英國政府在一九九九年刊印了一份名為 The National Service Framework for Mental Health 的政策性文件，由此開始了過去十年的精神健康改革。本文主要探討在社區照顧、服務評估、精神健康資源投放、病人經驗、先進治療、安全病房環境及預防自殺等不同範疇的改革。整體來說改革的成效不錯，上述各方面都有一定的進步。文中期望未來可以改善以下四方面：心理治療、精神病人就業問題、少數族裔服務及失智症照顧。精神健康改革涉及大量資源投放，在資源的限制下，改革要走的路仍然漫長。