Investment in mental health: a battle for resources

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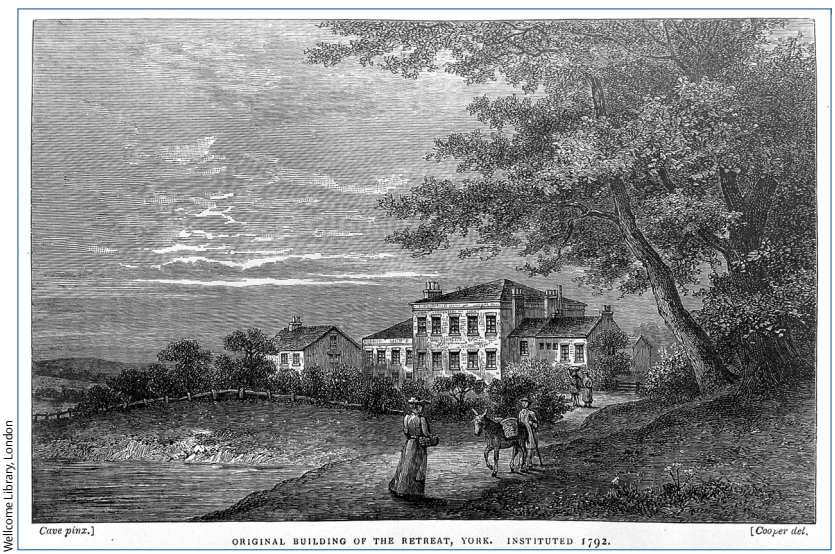
In *Description of the Retreat*,[1] Samuel Tuke observed that "of all the modes by which the patients may be induced to restrain themselves, regular employment is perhaps the most generally efficacious". Being gainfully employed is a cherished goal of many people with mental disorders. Interventions such as individual placement and support can improve patients' chances of being employed.[2] In first-episode psychosis, staff training in motivational interviewing further enhances the effect of individual placement and support.[3] Meaningful activity is not simply working; it gives meaning in more than one way to one's being.

Despite the best available treatment, about 10% of people with schizophrenia will end up in a chronic, enduring, and seriously disabling state. At this severe end, patients have very low levels of meaningful activity, let alone paid employment. Evidence is scarce to guide clinicians on how to improve functional outcomes of this group. In *The Lancet Psychiatry*, Helen Killaspy and colleagues[4] report findings of a cluster-randomised trial of an intervention designed to increase patients' engagement in activities, which was set in 40 mental health rehabilitation units in England. 20 units were randomly allocated to receive the intervention, which consisted of a manual-based staff training programme delivered by a specific intervention team; the other 20 units continued to provide standard care. Despite rigorous efforts to ensure intervention fidelity, 12 months after randomisation, no improvement was seen in patients' engagement in activities or functioning, compared with standard care (coefficient 1·44, 95% CI –1·35 to 4·24). Killaspy and colleagues postulate that the absence of clinical effect might be because the staff training did not lead to sustained change in practice, that current turbulence in the NHS prevented staff from delivering the intervention consistently, or that patients were impaired too severely to benefit from the intervention.



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The last possibility gives food for thought. In all chronic medical disorders, a subset of individuals exist who will have a poor outcome despite the best possible care. We accept this effect as natural heterogeneity in the course and outcome of diseases. The population under study by Killaspy and colleagues represents such a subset. Patients were being managed in small community-based units, many of which are under threat of closure (as happened to one unit during the study). One rationale for deinstitutionalisation was the erroneous attribution of the impoverished lives of patients to the institution, rather than—as we later discovered—negative symptoms and cognitive deficits inherent in the disorder. So what should we do for this population?

First, we should acknowledge that this group exists, has complex needs, and currently ends up in virtual asylums that have developed in an unplanned manner, without any long-term strategy or investment, and are typically supplemented by very expensive private sector provision. Second, we need to alter the nature of debate in psychiatry, from polarised to complementary.

Debates in mental health invariably end up polarised: hospital bad, community good; medication bad, psychotherapy good; biomedical models are reductionistic and hence bad, psychosocial models are holistic and hence good. For policy makers and funders, such simple and divisive bifurcations make pitching one part of the service against another easy, shifting resources between them. Successful investment in community care has, at times, happened at the expense of inpatient care, thus leading to a self-fulfilling prophecy whereby underfunded inpatient units have become true to caricature: non-therapeutic and coercive rather than caring. In times of budget cuts, services further retreat into territorial battles, seeking to maintain their slice of a shrinking pie. The austerity era is already producing calls for functional teams to be subsumed into generic care,[5] potentially undoing hard won new investment into specialist care. We are beginning to see the negative effect of such changes. Trusts that have merged their specialist community teams (eg, assertive outreach, early intervention) with generic community services have higher suicide rates.[6] Cutting the number of psychiatric beds also leads to a corresponding increase in rates of detention in subsequent years.[7] Shifting resources from one part of the mental health system to another strengthens one bit but weakens the other. We need the entire care pathway to be robust.

A third sobering lesson can be taken from the findings of Killaspy and colleagues' negative trial: if even well-resourced units with determined input from dedicated teams do not improve patients' functioning at the severe end of the disorder, perhaps we should shed our current orthodoxy that demonises the asylum function of psychiatric care, to provide a place of safety, refuge, and protection. Until we make a major therapeutic breakthrough, we should ensure that we do not keep cutting the number of long-stay beds in the hope that simply discharging patients into the community will improve outcomes. Good mental health care needs investment in all aspects. No amount of community investment will ever obviate the need for some hospital beds. If communities were all that therapeutic, people would not fall ill in the first place. In the current climate, a real threat exists that specialist and generic services will be too busy fighting over resources rather than jointly arguing for increased investment in all aspects of mental health care, from generic to highly specialised.

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