Editorial

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Mental health support in crisis: bed shortages or lack of community support?

The crisis in mental health crisis care has been widely reported.

Many people who experience mental health crises, and their relatives, have spoken about the difficulties they have experienced in accessing help when they need it (see, e.g. Mind, 2011). Many have also described how they feel that they have been "batted away": told that they were "not ill enough" to warrant crisis care.

In a survey reported by the Commission to Review the Provision of Acute Inpatient Psychiatric Care for Adults (The Commission to Review the Provision of Acute Inpatient Psychiatric Care For Adults (CAAPC), 2015), to which 79 per cent of mental health trusts in England responded, average bed occupancy was 104 per cent. This results in many people being placed in beds far from their homes:

> Current estimates suggest that each month around 500 mentally ill people have to travel over 50km to be admitted into hospitals far from their own homes (The Commission to Review the Provision of Acute Inpatient Psychiatric Care for Adults (CAAPC), 2016).

Even when a bed can be found, the shortcomings in care provided on many inpatient wards has also been widely reported (see, e.g. Mind, 2011; Centre for Social Justice, 2011; CAAPC, 2015, 2016):

> Quality of life on the ward was terrible, it was a violent place to be. I was repeatedly hit and had things stolen but most of the nurses did not care. The hospital was filthy and the staff stressed and over-worked, access to different therapies was non-existent. They moved my bed eight times in four weeks!
>
> All staff time and resources are spent to stop bad things happening but not make good things happen (Mind, 2011, p. 22).

Some have argued that shortages of beds have resulted in more compulsory detentions. The number of compulsory detentions has indeed reached record highs. 2014/2015 saw the largest year on year increase ever in compulsory detentions of 10 per cent to 58,399 and 2015/2016 saw a 9 per cent increase to 63,622. This represents an increase of 47 per cent – 20,261 detentions – over the ten years since 2005/2006 (43,361)[1].

The response has often been to call for more inpatient psychiatric beds. However, this may not be where the real problem lies.

While it is true that the number of acute inpatient beds has decreased (by some 2,100 since 2010 – see McNicholl, 2015a) acute inpatient beds cannot be considered in isolation from community services. During the same time period, crisis and home treatment teams saw a cut of 8 per cent and an increase in demand of 18 per cent, early intervention in psychosis teams saw a 26 per cent cut and assertive outreach teams saw a 56 per cent cut (McNicholl, 2015a, b). Many assertive outreach teams have been dismantled with their functions being integrated into Community Mental Health Teams (CMHTs). However, these CMHTs have undergone considerable reconfiguration and remodelling in recent years (Gilbert, 2015) and themselves saw a small cut (0.6 per cent) and a large increase in demand (19 per cent) (McNicholl, 2015a, b):

> Any problems with community service provision can create significant pressure on acute inpatient beds (Gilbert, 2015, p. 7).

In their survey of acute psychiatric inpatient wards, CAAPC (2015) reported that:

> The main factors affecting pressures on beds were availability of housing (39%) and quality/resourcing of community teams (30%).

The majority of consultant psychiatrists who were responsible for inpatient psychiatric beds agreed, saying either that they had enough beds, or that they would have enough

beds if improvements were made to other community-based services and alternatives to acute admission (CAAPC, 2015).

Therefore it would appear that pressure on acute inpatient beds results primarily from the failure to provide effective community support either to prevent crisis or provide community-based alternatives to inpatient admission for people in crisis. However, in thinking about community support for people with mental health challenges, it is important to look beyond CMHTs.

First, many voluntary sector mental health organisations providing important support to people with mental health challenges have seen their funding cut as the budgets of local authorities have been squeezed. While both statutory and voluntary sector community mental health services are being reduced, pressure on inpatient services will continue to rise.

Second, the social determinants of mental health problems cannot be ignored (see Marmot, 2015). Homelessness, poverty, social isolation and unemployment all generate or exacerbate mental health problems, and increase the likelihood of suicide (see, e.g. Royal College of Psychiatrists, 2002). The social conditions of many people with mental health problems have worsened over recent years.

The availability of affordable, social housing has decreased and too many people get stuck in hospital because of a lack of availability of suitable housing. The employment rate of all people with mental health problems stands at 43 per cent – some 22 per cent below the employment rate for people with other health conditions (65 per cent) and 31 per cent below that of the general population (74 per cent). For people being supported by secondary mental health services the employment gap rises to 65 per cent compared with the general population (Mental Health Task Force, 2016). This, combined with attempts to cut the welfare bill, mean that many people with mental health problems are living in poverty. In this context it is important to note that the poverty of an increasing number of people who have mental health problems has been exacerbated by welfare benefit sanctions – having their welfare benefits stopped for a period of weeks to enforce compliance:

> A joint analysis of the figures by the *Independent* and the mental health charity Mind found that 19,259 people with such conditions had their benefits stopped under sanction in 2014-15 compared to just 2,507 in 2011-12 – a 668 per cent rise (Stone, 2015).

Social isolation is also a major problem for people experiencing mental health problems (Office for Disability Issues, 2013). The provision of a brief visit from a CMHT cannot hope to replace the friends and social networks on which we all rely.

It is highly likely that rising homelessness, worklessness, social isolation and poverty have contributed to the increase in demand on mental health services. Unless we attend to the wider social determinants of mental health and assist people in these areas, pressure on mental health services is likely to increase substantially.

There have been numerous initiatives to improve care in crisis, most notably the Crisis Care Concordat[2] developed in 2014. This sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

"The Concordat focuses on four main areas:

1. access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously;
2. urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency;
3. quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment; and
4. recovery and staying well – preventing future crises by making sure people are referred to appropriate services (see www.crisiscareconcordat.org.uk/about/)".

This, and other initiatives, have spawned many local innovations like "Street Triage" pilots to reduce use of Section 136 of the Mental Health Act, a range of crisis houses and non-residential

crisis alternatives like "The Haven" in Bradford and "Leeds User Run Crisis Service" (available at: www.crisiscareconcordat.org.uk/local-inspirations/). Yet these remain small-scale initiatives and most people continue to find it difficult to get help in crisis, help before they reach crisis point and help to stay well. It is noteworthy that, despite the Crisis Care Concordat, use of Section 136 (where a person is removed from a public place by the police and brought to a place of safety) continues to rise: an increase of 18 per cent from 2014/2015 to 2015/2016 and a four-fold increase over the last ten years[3].

The impression within most mental health services is one of mental health workers "manning the barricades" of a beleaguered castle trying to ward off the marauding hordes lest they be over-run. Via their initial assessments, mental health professionals select those whose problems are severe enough to warrant community support or admission. As one person said:

> It feels like I literally have to have one foot off the bridge before I can access services (Mind, 2011, p. 18).

With a very few small, local exceptions, most people cannot find the "Access to support before crisis point" envisaged in the crisis care concordat. The Care Quality Commission (2015) found that many people experienced problems in getting help when they needed it, that the care they received was of variable quality depending on where they lived, and that the reception they received from healthcare professionals fell short in terms of warmth and compassion.

Neither can they find the community support they need to remain well. Evidence from the 2016 Community Mental Health Survey (Care Quality Commission, 2016) clearly shows that mental health services are failing to provide the support that people need in these areas:

- in total, 28 per cent of those using secondary mental health services had definitely received help to find or keep work while 43 per cent would have liked such help but did not receive it;
- in total, 32 per cent said they definitely received help with welfare benefits/finances while 43 per cent would have liked such help but did not receive it; and
- in total, 30 per cent of people definitely received help to access community activities while 41 per cent would have liked such help but did not receive it.

These figures stand in marked contrast to the availability of psychological therapies where the position was reversed: 46 per cent had received therapy while only 26 per cent would have liked it but did not receive it.

If we are really to reduce pressure on beds then two things are likely to be necessary.

First, we must make sure that people receive the help they need to stay well and live valued and contributing lives as part of their communities. This must include not only treatment, but attention to all the social determinants of mental health. There are local examples of good practice, some of which have been described in the pages of *Mental Health and Social Inclusion* (see, e.g. Walters, 2015; Perkins *et al.*, 2015). But these must become the rule rather than the exception.

Second, we must make sure that "people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously" (www.crisiscareconcordat.org.uk/about/). This will require not only the development of genuinely accessible and welcoming support, 24 hours per day, 365 days per year. It will also require a change in perspective. The belief that "the professional knows best" is firmly entrenched in most crisis services. Maybe it is time to start believing people when they tell us that they are having problems and that a crisis may be looming rather than send them away as "not ill enough". Maybe it is time to stop "manning the barricades" and "let down the drawbridge"?

Notes

1. Source: Health and Social Care Information Centre, available at: www.content.digital.nhs.uk/catalogue/PUB22571/inp-det-m-h-a-1983-sup-com-eng-15-16-rep.pdf
2. www.crisiscareconcordat.org.uk/about/
3. Source: Health and Social Care Information Centre, available at: www.content.digital.nhs.uk/catalogue/PUB22571/inp-det-m-h-a-1983-sup-com-eng-15-16-rep.pdf

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