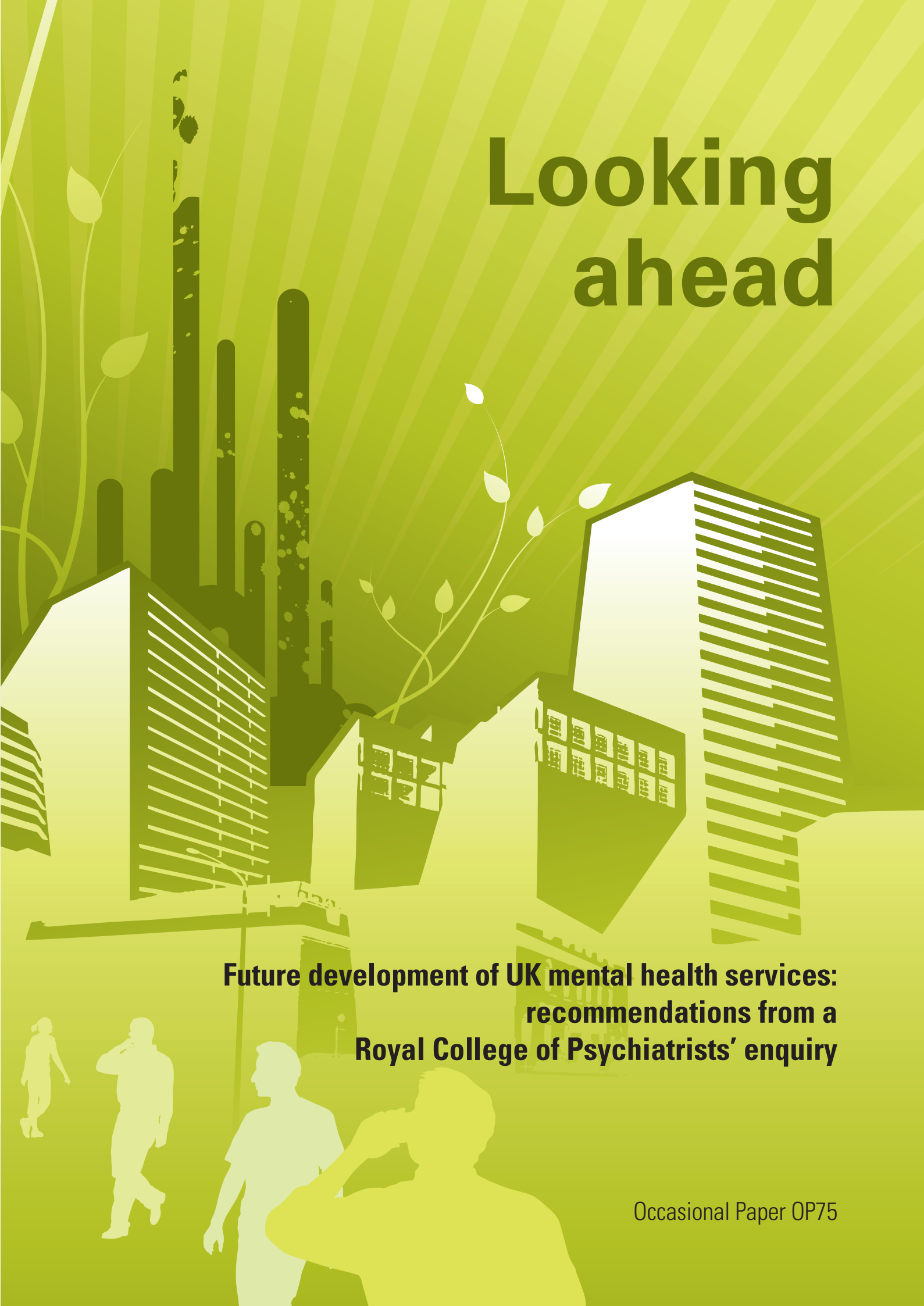
Looking ahead



Future development of UK mental health services: recommendations from a Royal College of Psychiatrists' enquiry

Occasional Paper OP75

Looking ahead

Future development of UK mental health services: recommendations from a Royal College of Psychiatrists' enquiry

Occasional Paper OP75
June 2010

Royal College of Psychiatrists
London

Contents

Foreword

In the 60 years of the National Health Service (NHS) there has probably never been unanimity of view on the design of mental health services. Every generation has brought its priorities, trends and pendulum swings; every crisis has brought its reactions – and sometimes its overreactions. Courts, governments, academics and patient and carer advocates have all had their say and their influence. Macaulay's ranks of Tuscany come to mind: 'Those behind cried: "Forward!" And those before cried: "Back!"'

When I was invited by the President of the Royal College of Psychiatrists to chair this review of UK mental health service design, I did not expect to find unanimity and, in that, I was not disappointed. But as we held our hearings and conferences and read submissions, what was rewarding was the enthusiasm of our interlocutors and the richness of their evidence. I am grateful to the College for initiating this review and to all those who gave us their experience and expertise and their thoughts for the future.

Of all the responsibilities I have held in health over 27 years and two Parliaments, none has hooked me more than mental health. I used to say that when I took on this policy area in government, I thought I knew it all; after a year I knew I didn't and after 2 years I realised nobody else did either. Ever since, I have been fascinated by it and devoted to making improvements in it. I am grateful to all those who gave their time with the scoping for this study.

John Bowis, OBE
Chair of the project
Honorary Fellow of the Royal College of Psychiatrists

Introduction

In September 2009, the Royal College of Psychiatrists – in association with the NHS Confederation's Mental Health Network and the London School of Economics and Political Science – held a seminar on the economic downturn and mental health.

Taking soundings from leading figures from the worlds of mental health and health economics, the seminar explored how mental health services might best respond to the undoubted challenges presented by the economic downturn. A subsequent report *Mental Health and the Economic Downturn* (Royal College of Psychiatrists *et al*, 2009) contained a number of recommendations. However, one of the overriding messages from it was that there exists not only a need, but also an opportunity, for service redesign in mental health, and it is this opportunity that the present document seeks to pursue.

This summary and set of recommendations draws on evidence given during hearings held in February 2010, a number of written responses submitted to the enquiry's evidence committee, and presentations delivered at a one-day seminar held in March 2010.

Although exhaustive neither in its scope nor in the breadth of those from whom it sought evidence, the enquiry nevertheless represents a serious effort to consider service redesign in mental healthcare and to give voice to the people who work at the heart of our mental health services. This document aims to identify areas for future service development that reflect the needs and aspirations of users of mental health services, those who care for them and also the people who deliver those services.

The document is a distillation of the views of a broad church, comprising more than 50 psychiatrists, psychologists, nurses, occupational therapists, social workers, commissioners, trust chief executives, academics, health economists, voluntary sector organisation chief executives, service users, carers, medical directors and national mental health programme leads.

During the enquiry, evidence was collected from contributors across the four countries of the UK (where internal structures and arrangements may differ, and indeed where further regional differences may also exist). Consequently, this evidence is employed to reflect on the common challenges facing mental health services. The contributors were asked to consider a number of areas, including:

- positives and negatives from the past 10 years of mental health service reform
- how best to organise services to provide the best outcomes for service users

- reconciling tensions between generalist and specialist approaches to care
- how best to achieve effective collaboration between different health services
- how to better manage transitions between services, or parts of a service, to ensure comprehensive care and continuity for service users
- how to better integrate health, social care, non-statutory/voluntary sector, employment and criminal justice services.

A digest of the many and various views expressed by witnesses and contributors – and from which this summary and set of recommendations has been distilled – is available on the College's website (at www.rcpsych.ac.uk/redesign).

Summary and recommendations

Through written and oral evidence, contributors provided the enquiry with a wealth of material on mental health service redesign. In broad terms, the enquiry found that concepts such as self-management, recovery and personalisation enjoyed widespread, multidisciplinary support. However, how best to realise the social model of mental health on which these concepts are grounded – and which requires the active participation of the wider community in order that service users are empowered to take an active and equal part – was a contested issue and a consensus on potential solutions did not emerge.

Delivering services through a 'mental wellness' approach also had considerable support, with some commissioners and providers already taking steps in this direction through, for example, the development of service lines and the creation of well-being services in primary care. These reflect growing recognition of the need to innovate to address the substantial loss of life-years which patients with severe mental illness continue to experience, and to configure services in such a way that they can better provide the evidence-based treatments (e.g. psychological therapies) to which service users and carers are entitled.

Creating efficiencies and improving productivity through redesigned services and care pathways

Community mental health teams (CMHTs)

The enquiry found that there needs to be a rebalancing of resources and membership between community mental health teams (CMHTs) and specialist/functionalised teams (i.e. assertive outreach, crisis resolution, early intervention in psychosis). Some contributors expressed enthusiasm for an enlarged CMHT model, where a degree of specialism is contained within the larger team. The enquiry concluded that the idea of an enlarged CMHT needs further consideration and the balance between general community care and specialised teams should be re-examined.

'Service line' models

Service lines are care pathways comprising different service components, which are managed as discrete 'business units' to provide efficient, timely and appropriate multidisciplinary health and social care to individuals on the

basis of their needs. Individuals' needs are identified in a clinical assessment early on in the pathway, and patients are 'clustered' according to need into the appropriate service line.

Some elements of this model – for example, delegation to clinicians, information accountability and authority to change services to bring about operational and management efficiencies – are core to consultant psychiatrists' leadership role, but there remains a serious danger that it will engender the 'silo' mentality in which services become protective of their own areas rather than having an overview of the pathways that patients follow.

Recommendations

1 The relationship between community teams and specialist teams should be examined with a view to rebalancing their roles, and the model of an enlarged CMHT should be further explored.

2 A whole-system comparison of the different models of mental healthcare (e.g. service lines, functionalised teams, enlarged CMHTs) should be carried out urgently, with adequate resources made available for this comparison to be made. To achieve this, outcome measures devised in Recommendation 6 may need to be explored. The comparison should aim to furnish the mental health sector with high-quality data on interventions and outcomes of the various prevailing approaches.

Consultant expertise at the beginning of the pathway

Configuring pathways so that consultants' expertise is used in (a) complex assessment and management, (b) rapid review of those in crisis and (c) advice both to multidisciplinary teams and staff working in primary care was an area of debate throughout the enquiry, as was the development of primary care psychiatry.

Using consultants' or other experienced team members' expertise to carry out assessments at the beginning of the pathway is congruent with the fact that assessments are often ongoing processes rather than one-off events.

Although the integration of psychiatry into primary care is a potentially fruitful and extremely welcome development – given the robust evidence base from countries such as the USA – a thorough evaluation of this kind of practice is indicated in the UK.

Recommendations

3 Consultants' expertise should be used in complex assessment and management, rapid review of those in crisis, and advice to multidisciplinary teams and staff working in primary care.

4 Services should be organised in such a way that appropriate expertise is available to ensure that the ongoing assessment of service users' needs is a routine aspect of the care they receive.

5 Research should be carried out into the clinical effectiveness and cost-effectiveness of primary care psychiatry services in the UK.

Standardised outcomes

Changes to one part of the care pathway can have unintended effects on the whole system. It is therefore imperative that whole-system comparisons of the different models of mental health service provision are carried out.

These different systems should also be evaluated, using a common system of data collection (including measures of cost-effectiveness) and outcome measures relevant to commissioners, clinicians, service users and carers. Both urban and rural systems need to be looked at.

Recommendation

6 Although some measures exist, it is urgent that standardised outcome measures for mental health services and service users are identified; the Royal College of Psychiatrists and other professional bodies should undertake this work.'

Investing to save through the development of family mental healthcare

The majority of serious mental health problems among working-age adults begin early in life and cause disability when those affected would normally be at their most productive (Friedli & Parsonage, 2007). Furthermore, some illnesses cluster in certain families. Family-oriented mental healthcare – i.e. clinical services which look after families rather than just individuals – has the potential to lead to substantial cost savings by preventing the loss of productivity that persistent mental ill health over the life-course can cause.

Recommendation

7 Research should be carried out to evaluate the clinical effectiveness and cost-effectiveness of (a) family-oriented mental healthcare jointly coordinated by adult mental health services and child and adolescent mental health services and (b) family-oriented mental healthcare delivered through family psychiatry services (where ill members of the same family are looked after by the same clinical team over the lifespan, as happens in some primary care settings).

Out-of-area treatments

Some areas of the mental health system offer opportunities for immediate redesign. These include the 'out-of-area treatments' system (out-of-area treatments being independent-sector provision of in-patient, residential and nursing care placements situated away from the service user's home area).

Vast amounts are spent annually by commissioners and local authorities on out-of-area treatments, many of which are not clinically justified (Killaspy & Meier, 2010). Reinvesting this money could provide more appropriate local services, such as rehabilitation services and supported accommodation, that help service users to achieve greater autonomy and independence (Killaspy *et al*, 2009).

Recommendation

8 Commissioners and local authorities should – as a matter of urgency – review their systems and invest expenditure currently used to fund unnecessary out-of-area treatments into the local mental health economy (and specifically into rehabilitation services provided by the statutory and voluntary sector).

Mental health of older people

Equitable access to services across different populations (such as Black and minority ethnic groups) was identified as important throughout the enquiry. Similarly, with potential increases in cases of dementia, service redesign and development for older people should ensure that people over 65 have equitable access to the range of mental health services and that these services are age-appropriate and non-discriminatory.

An arbitrary age cut-off is not a satisfactory criterion for determining the service that a person receives; rather, services must be commissioned, configured and developed locally to better meet the needs of older people and to eliminate discrimination. Access to a full range of mental health services can result in significant cost savings through reductions in the prescribing of antipsychotic drugs, use of GP time, days spent in hospital, planned and unplanned hospital admissions and admission to care homes among older patients (Anderson *et al*, 2009).

Recommendation

9 Commissioners and providers must ensure that people over 65 have equitable access to the full range of age-appropriate and non-discriminatory mental health services required to meet their needs. Comprehensive specialist older people's mental health services are an essential part of meeting need across the lifespan and must be available in all commissioning areas.

In-patient care

In-patient services are a fundamental part of the whole care system. In-patient care must be valued as an important element of the care pathway and it should be provided by staff skilled and resourced to involve service users using the best evidence for their recovery.

Different models of in-patient care, including assessment wards, the integration of crisis teams with wards and crisis houses, and other alternatives to admission or facilitation of discharge must be evaluated thoroughly.

Comparison of bed utilisation across similar populations through agreed data collection (an extension of that currently collected by the National Audit Office) would help to identify ways of reducing high bed occupancy and enabling reduction of ward size to the recommended 15 beds with 85% occupancy, allowing better access to local hospital provision.

Recommendation

10 Research should be carried out to evaluate different models of in-patient care and discharge procedures across the system as a whole.

Statutory and voluntary sector partnerships

Although developments such as peer support (see below) might gain only qualified support, they nevertheless reflect a growing trend among commissioners and providers away from a system of CMHT case management and out-patient clinics towards a more purposeful suite of inputs in primary care. To this end, the increasing use of partnerships or 'compacts' between the statutory and voluntary sectors offers potential for cost-effective and clinically effective care which service users may find less stigmatising and which is associated with greater levels of service-user engagement (National Strategic Partnership Forum, 2006; Tait & Sonal, 2007).

Recommendation

11 The use of partnerships or compacts between statutory and voluntary sector agencies to develop the availability and quality of step-down services from secondary and primary care should be increased.

Housing

One particular sector in which greater partnership between social care agencies and the voluntary sector is urgently required is housing. Good practice can help service users to attain confidence and skills as they recover from mental health problems, and such partnerships should be strongly encouraged, the enquiry concluded, through responsible commissioning.

Some contributors thought housing problems to be a reason for delayed hospital discharge. Ideally, discharge planning should start within days of admission, and specialist staff or teams with in-depth understanding of the local housing economy and referral systems should be encouraged. These staff members should coordinate referrals to supported accommodation across health, social services and third-sector providers to ensure that referrals are appropriately matched to clinical need.

Recommendation

12 Greater partnership working is required between health services, social services and the voluntary sector to facilitate timely and safe step-down accommodation. Services should employ suitably experienced staff to liaise with local housing departments regarding discharge, and contact should be made within days of patient admission.

Employment and mental health

Employment and mental health was also identified as important. The enquiry concluded that organisations with a workforce over a certain size should report annually on their mental health at work policy as part of their report on health and safety at work. This would be an inexpensive, non-prescriptive process, which is nevertheless legally required, that would encourage employers to reflect on the mental welfare of their employees.

Recommendation

13 Organisations with a workforce over a certain size should be required to report annually on their mental health at work policy, as part of their report on health and safety at work.

Substance misuse

Service users with comorbid substance misuse are currently excluded from some primary and secondary mental health services. However, research shows that interventions for people with schizophrenia and comorbid substance misuse are superior and no more expensive in the short-term than standard care (Haddock *et al*, 2003). They may also produce longer-term cost savings by reducing psychiatric symptoms, reducing the use of institutional services, improving medication adherence, reducing levels of homelessness and reducing contact with the criminal justice system (Department of Health, 2002; Judd *et al*, 2003).

Given the high rates of substance misuse among people with mental health problems, denying them access to services only further excludes vulnerable members of society and deprives them of potentially beneficial treatment. Accessible services staffed by professionals with appropriate training in dual diagnosis and substance misuse can reduce the frustration that service users and carers report about undergoing assessments by numerous different agencies (Revolving Doors Agency, 2009). Such provision also has the potential to deliver financial benefits for services, through reductions in the duplication of assessments without increasing costs, even with the additional staff training required (Hoff & Rosenheck, 1999).

Recommendation

14 Mental health services should remove dual diagnosis/substance misuse as an exclusion criterion and ensure that staff are trained in substance misuse issues.

Relationship between physical and mental health

There is still much to be done to bring about a genuinely whole-person approach to care and treatment. The consequences of a failure to diagnose and treat individuals for both physical and mental health symptoms are serious and costly. Similarly, the costs to health services of treating medically

unexplained symptoms are significant. A renewed emphasis on liaison psychiatry and psychology services is required, including consultant-led services that aim to reduce acute medical and surgical bed occupancy and acute attendances of individuals with unexplained physical symptoms. The College has led on a web-based forum involving several other medical Royal Colleges to share experiences.

RECOMMENDATION

15 Action is required to ensure that the link between physical and mental health is addressed by all health services.

PSYCHOLOGICAL THERAPIES

Although there has only been a partial roll-out of NHS psychological therapy services across the UK, a range of voluntary sector providers – including homelessness and substance misuse charities – nevertheless expressed positive experiences of providing treatment based on the Improving Access to Psychological Therapies (IAPT) programme model. The increase in primary care triage/liaison services providing integrated care from psychology and psychiatry for common mental health disorders and delivering IAPT was also perceived as an encouraging development.

RECOMMENDATION

16 Access to evidence-based psychological interventions/therapies is required at all points along the care pathway, and should be needs-led; within 5 years there should be the same availability of psychological therapies as evidence-based medical interventions.

PEER SUPPORT

The enquiry heard that the employment of peer support workers is both a cost-effective and recovery-oriented method for providing personalised support and assistance to people using mental health services, and an approach that can reduce admissions to hospital and shorten length of hospital stay (Solomon, 2004; Lawn *et al*, 2008). However, there were contrasting views on this in the UK context: some contributors questioned whether it is appropriate to develop practice in this area on the basis of research largely conducted outside the UK, and others viewed it as the creation of an artificial 'community' which does little to address problems of stigma or prompt the wider community into taking more responsibility. More work is required on this as a matter of urgency.

RECOMMENDATION

17 Piloting and evaluation of the clinical effectiveness and cost-effectiveness of the use of peer support workers in mental health services should be carried out in the UK.

References

Anderson, D., Banerjee, S., Barker, A., *et al* (2009) *The Need to Tackle Age Discrimination in Mental Health: A Compendium of Evidence*. Faculty of Old Age Psychiatry, Royal College of Psychiatrists.

Department of Health (2002) *Dual Diagnosis Good Practice Guide*. TSO (The Stationery Office).

Friedli, L. & Parsonage, M. (2007) *Mental Health Promotion: Building an Economic Case*. Northern Ireland Association for Mental Health.

Haddock, G, Barrowclough, C., Tarrier, N., *et al* (2003) Cognitive–behavioural therapy and motivational intervention for schizophrenia and substance misuse: 18-month outcomes of a randomised controlled trial. *British Journal of Psychiatry*, **183**, 418–426.

Hoff, R. & Rosenheck, R. (1999) The cost of treating substance abuse patients with and without comorbid psychiatric disorders. *Psychiatric Services*, **50**, 1309–1315.

Judd, P., Thomas, N., Schwartz, T., *et al* (2003) A dual diagnosis demonstration project: treatment outcomes and cost analysis. *Journal of Psychoactive Drugs*, **35** (suppl. 1), 181–192.

Killaspy, H. & Meier, R. (2010) A Fair Deal for mental health includes local rehabilitation services. *The Psychiatrist*, **34**, 265–267.

Killaspy, H., Rambarran, D., Harden, C., *et al* (2009) A comparison of service users placed out of their local area and local rehabilitation service users. *Journal of Mental Health*, **18**, 111–120.

Lawn, S., Smith, A. & Hunter, K. (2008) Mental health peer support for hospital avoidance and early discharge: an Australian example of consumer driven and operated service. *Journal of Mental Health*, **17**, 498–508.

National Strategic Partnership Forum (2006) *Making Partnerships Work: Examples of Good Practice*. Department of Health.

Revolving Doors Agency (2009) *New Horizons – Towards a Shared Vision of Mental Health*. *Consultation Response 15th October 2009*. Revolving Doors Agency.

Royal College of Psychiatrists, Mental Health Network, NHS Confederation, *et al* (2009) *Mental Health and the Economic Downturn: National Priorities and NHS Solutions (Occasional Paper OP70)*. Royal College of Psychiatrists.

Solomon, P. (2004) Peer support/peer provided services: underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal*, **27**, 392–401.

Tait, L. & Sonal, S. (2007) Partnership working: a policy with promise for mental healthcare. *Advances in Psychiatric Treatment*, **13**, 261–271.

Occasional Papers have not been formally approved by the Central Executive Committee and do not constitute College policy. Their distribution has been authorised by the College's Officers with the aim of providing information or provoking discussion.

For full details of reports available and how to obtain them, contact the Book Sales Assistant at the Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG (tel. 020 7235 2351, fax 020 7245 1231).

The Royal College of Psychiatrists is a charity registered in England and Wales (228636) and in Scotland (SC038369).