Scottish Needs Assessment Programme

Mental Health: Effects of the Changing Patterns of Service Provision and their Health, Social and Economic Implications

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Priority Services Network

Mental Health: Effects of the Changing Patterns of Service Provision and their Health, Social and Economic Implications

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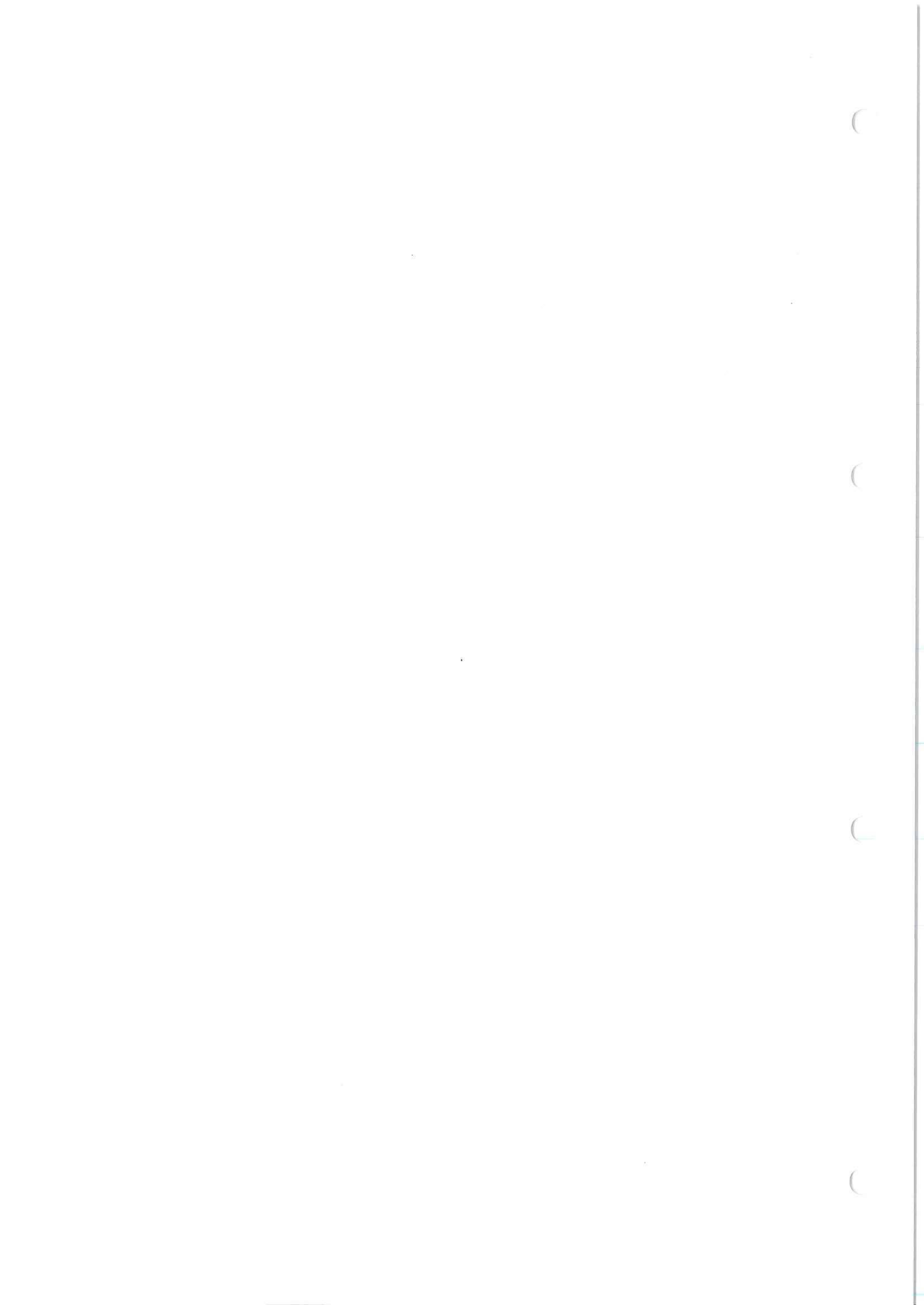

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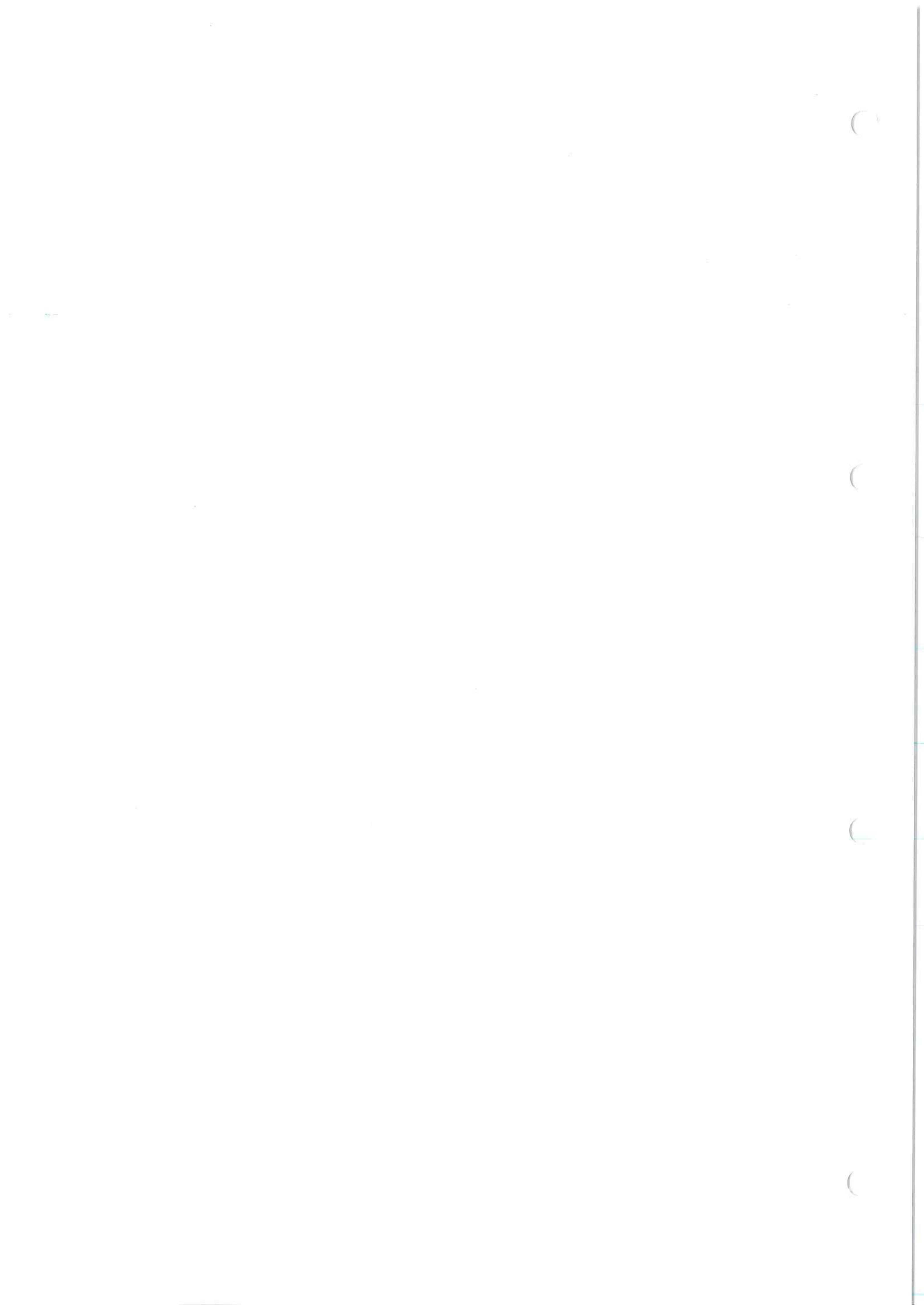

EXECUTIVE SUMMARY

This Report develops one of the five areas identified in the SNAP Mental Health Overview Report issued in January 1995, focusing on the commissioning of services for adults with a mental health problem. It reiterates the importance for health commissioners of mental health services of a recognition of the need for collaboration with contiguous social care provision, of the development of joint mental health strategies and of the promotion of partnerships, including joint commissioning. Commissioning must be informed by local assessment of population needs.

For each of the major areas of provision, where the state of evidence is sufficiently advanced, best practice information on commissioning is outlined. With the increasing emphasis on community based provision, it is essential that the commissioning of adequate resources for those requiring in-patient treatment is not neglected. Precise bed requirements will vary with local circumstances and should be subject to review as increasing community resources are put in place. For more specialist provision consideration should be given to cross boundary commissioning. There should be clear protocols for both hospital admission and discharge.

In terms of community provision, GPs provide a key gatekeeping function. Attention needs to be paid both to the resources available to GPs and to clear referral routes for more specialist services. Increasingly the individual commissioning decisions of GPs need to be monitored.

There is evidence that many mental health services are spread indiscriminately across different levels of need. As a consequence services may be diverted from those with serious and long-term mental health problems. CPN skills in particular fall into this category and their energies need to be redirected with the aim of focusing on those with more severe mental health problems.

Specialist skills should be complemented by the employment of community support workers able to offer a range of key support functions. This should allow a clearer specification of the roles of each of the primary care team members and the development of clear protocols for service access.

Psychiatry needs to respond to the changing environment with a greater emphasis on psycho-social models of care. Psychiatric provision must be a comprehensive, integrated service which transcends the hospital / community divide and is sector based.

The presumption for the organisation of the different elements of community health provision for those with mental health problems should be a multi-disciplinary and multi-agency team The juncture with the primary health care team needs to be carefully managed. Clear evidence is emerging of the key requirements of the community mental health team. Their priority user group must be the individual with serious long-term mental health problems. Each team should have a manager with clear operational management responsibilities and should have the skill mix to provide a full range of services. Eligibility criteria should be widely publicised and gatekeeping should be enforced.

It is essential that one person holds key responsibility for the co-ordination of services to the individual with long-term mental health problems. Currently confusion exists between the underdeveloped Care Programme Approach (health-led) and the care management responsibilities of the local authority and this must be resolved. The professional background of the individual allocated as care manager should be determined according to the needs of the service user. Mechanisms should be developed to allow care managers from a range of agencies.

Health commissioners need to include within their commissioning strategies provision for both emergency and crisis responses. It is useful to distinguish these two elements, even though the service responses may overlap. Equally essential to comprehensive mental health provision is access to respite care. Health commissioners need to determine their own contribution vis-a-vis social care providers and where necessary to initiate resource transfer. As with arrangements for crisis and emergency provision, there needs to be careful evaluation of a range of models.

The credibility of any mental health strategy will rest on the success with which provision is maintained for the small group with enduring mental health problems who do not readily engage with services. The effectiveness of assertive outreach has been comprehensively demonstrated, but there needs to be careful specification of those on whom it should be targeted.

All commissioning decisions need to be informed by consideration of the specific health, social and economic needs of particular groups. These include women, carers, individuals from black and ethnic minorities, those who are homeless and those living in rural areas.

Those concerned with the commissioning of services to meet current needs should not neglect the underlying need for a preventive focus. A philosophy of prevention wherever possible should underpin any strategic approach to mental health problems.

Much can be learnt for the changing pattern of service provision from carefully evaluated experience elsewhere. The evaluation work undertaken by the Team for the Assessment of Psychiatric Services, for example, provides important evidence of the features that need to be addressed as part of any closure programme; lessons from such sources should be fully utilised.

A particular feature of transition to a predominantly community base is the need to provide opportunities for retraining and the acquisition of additional skills. Training should be tailored to the local situation, and should be focused on the development of partnerships, the identification of local needs and on local operational issues. It should include an element for professionals on how to enable users to become involved.

Finally, commissioning practice itself needs to be subject to careful scrutiny, defining and monitoring the outcomes of care, developing and disseminating best practice information, and evaluating alternative models for service provision. Different models of service development need to be evaluated, including economic evaluation. Consideration should be given as to how SNAP should co-operate with other groups to ensure that future research is targeted on areas identified as priorities.

RECOMMENDATIONS

R1 Joint planning partners should ensure detailed identification of the groups and numbers of individuals with mental health problems in the local population and their needs.

R2 Strategic commissioners need to be alert to the impact of individual GP commissioning decisions and to monitor their impact.

R3 Commissioners should specify and monitor the case mix of CPNs, with the aim of focusing on those with more severe mental health problems. Adequate incentives, training and support should be given.

R4 Commissioners need to ensure that all members of the primary care team are clear of their own role with regard to individuals with mental health problems, with be clear protocols in place to ensure that those in greatest need gain access to more specialised services.

R5 The employment of community support workers meets an essential need and allows more appropriate targeting of other skills. Their work must be carefully integrated.

R6 Psychiatry must be a comprehensive, integrated service which transcends the hospital / community divide and is sector based. All initial referrals should be seen at a community base.

R7 CMHTs should be clear that their priority user group is the individual with serious long-term mental health problems. Eligibility criteria should be widely publicised and there should be an effective gatekeeping system.

R8 CMHTs should not normally be based in primary care settings, but priorities should be agreed with the primary health care team.

R9 Each CMHT should have a manager with clear operational management responsibilities.

R10 CMHTs must have an appropriate skill mix to provide a full range of services; full-time commitment should be maximised and individual roles should be clearly defined. Services should be on offer outwith the 9 to 5 day.

R11 The confusion between the care programme and care management should be resolved. This should include clarity as to who should be included within each system.

R12 The professional background of the individual allocated as care manager should be determined according to the needs of the service user. Mechanisms should be developed to allow care managers from a range of agencies.

R13 A system for immediate and skilled response to individuals in an emergency is a prerequisite for comprehensive community mental health provision. It provides an essential service to users and reassurance to carers and the public.

R14 Services accessible in a period of crisis must be available to each locality. Access to such services needs to be carefully managed to ensure effective targeting.

R15 Commissioners must ensure through collaborative planning mechanisms that individuals will be able to access a range of respite care arrangements. Although the responsibility for the majority of such provision lies with social care agencies, there should be resource transfer to reflect the traditionally health based response to this need.

R16 Provision of an assertive outreach service must be of the highest priority in order to offer continuity and consistency to individuals with enduring needs.

R17 There should be clear specification of local bed requirements for particular groups based on an understanding of local need. Consideration should be given to cross boundary commissioning of more specialised provision.

R18 There needs to be a sensitivity throughout the commissioning framework to the needs of specific groups, for example black and ethnic minorities, those with multiple disabilities, those who are homeless or live in rural areas, and those who are carers.

R19 Programmes for hospital closure must include provision for the retraining of staff for community settings, with a review of the skills needed in delivering community mental health care in a multi-agency and multidisciplinary setting. This should extend to all clinical and managerial staff.

R20 Boards should support the development of outcome measures and evaluation of services subject to proposals meeting methodological criteria which suggest results will be valid and generalisable. Consideration should be given as to how SNAP should co-operate with other groups to ensure that future research is targeted on areas identified as priorities.

1 INTRODUCTION

The SNAP Report on Mental Health was circulated in January 1995. The necessity of a multi-disciplinary and multi-agency approach was emphasised, and five areas of priority for further work were identified.

- epidemiological monitoring of mental health in Scotland
- mental health in the workplace
- suicidal behaviour among young people
- effects of the changing patterns of service provision and their health, social and economic implications
- involvement of users and carers in assessing need for, commissioning and monitoring mental health services

Working groups are due to report in each of these areas. The current document should be read in close conjunction with that relating to the involvement of users and carers; the consultation exercises undertaken by that group have not been duplicated. It should be noted that this report focuses on the care of adults with mental health problems and does not include the commissioning of services for individuals with dementia which is being addressed in a separate report.

A number of related documents currently in circulation should also be noted. The CRAG Working Group on Mental Illness works though a series of Good Practice Groups. Good Practice Statements have recently been issued on Services for People Affected by Schizophrenic Illness (1995), on Primary Care and Community Care Services (1996), and on Primary Prevention of Mental Health Problems (1996). A Statement on the Development of Outcome Measures in Acute Psychiatry is expected shortly. More generally, there has been a background of major reports exploring the implementation of community care for those with mental health problems (Audit Commission, 1994; Health Committee, 1994; Mental Health Foundation, 1994; Clinical Standards Advisory Group, 1995; Department of Health, 1995).*

Health/social care interrelationships

The recognition in the parent SNAP report that the nature of mental health problems requires working across health/social care boundaries for much of the time has obvious implications for a document targeted at health service commissioners. Thus, while the elements for health commissioning are highlighted, the interrelationships with contiguous social care provision must be constantly acknowledged. The necessity for close collaboration over the planning and commissioning of services is a theme throughout this report and should be increasingly evidenced in the mental health strategies that Boards are currently

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* It should be noted that this report was prepared prior to the Scottish Office circulation of A Framework for Mental Health Services in Scotland. It is hoped that this report will contribute in the preparation of local mental health strategies.

development of partnerships, to include housing and the voluntary sector, in responding to the range of needs of those with mental health problems should also be an integral aspect of planning and purchasing.

Deinstitutionalisation

Although the large majority of those with mental health problems are outwith hospital, this report is of particular significance at a time of increasing focus on the reduction of long-stay beds. Whilst this is by no means the only dimension of changing service provision, it is useful to reflect on lessons which have been drawn world-wide from the process of deinstitutionalisation (Bachrach)

- it involves more than changing the locus of care : it is a social process with secondary consequences
- service planning must be individualised and tailored to the needs of specific patients
- it is essential to facilitate access to hospital care for patients who need it, for as long as they need it
- services must be culturally relevant
- patients must be involved in their own service planning to the fullest extent possible, likewise families
- service systems must be flexible and open to change.

Local needs

With these general principles as background, this report will explore the key areas to be addressed in purchasing decisions. It should be noted that although a specific section highlights particular needs contingent on gender, ethnicity or additional disability, such considerations are common to each section. A necessary prerequisite for informed purchasing is that as part of the development of local mental health strategies there must be adequate identification of the mental health needs of the local population. The responsibilities for planning and purchasing of services in response to these needs must be clearly defined, with joint commissioning where appropriate.

R1 Joint planning partners should ensure detailed identification of the groups and numbers of individuals with mental health problems in the local population and their needs

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Social disadvantage and mental health

Any examination of the effects of the changing patterns of service provision for people with mental health problems has to recognise that the group is not a homogenous one, either in terms of the patterns of poor mental health experienced or in the ways that good mental health can be promoted. The issue of health inequalities has to be addressed equally for this health problem as for any other.

While a number of studies indicate a link between high social class and good mental health, there is little research into the relationship between income and mental health. However, it does appear that social groups which experience the poorest mental health are also groups most likely to be experiencing poverty. People with poor mental health are at higher risk of poverty, but this does not adequately explain the relationship which appears in large measure to be linked with the stress of coping with adverse circumstances. It has been suggested that much of the social class differences in rates of depression arise from 'the fact that factors that appear to militate against the successful resolution of stress occur more frequently among low income groups than high income groups' (Blackburn, 1991).

Blackburn (1992), in her examination of the ways in which health and welfare services could improve their work with families in poverty, has identified a number of characteristics of helpful services. These include

- an integrated approach which meets financial, health and social problems as related
- a co-ordinated response whereby individual agencies work together
- services which offer realistic advice and recognise the limitations that poverty places on people; which do not merely provide help when individuals are in crisis and which do not individualise problems
- services which work in partnership with individuals, where individuals' contributions are valued, where there is recognition of what individuals do achieve in adversity and where they are not blamed for their poverty
- services which are permanent rather than constantly changing after two to three year periods because of the vagaries of funding
- services which are relevant, where they are not forced to define financial problems as emotional problems or personal inadequacy before help is given

Health promotion and mental health

There has been growing acknowledgement of the role to be played by activities aimed at preventing worsening health and providing early support in health generally; a similar trend has been evident in mental health services. The White Paper, *Health of the Nation*, (England and Wales) noted that health promotion in mental health has the opportunity to 'increase public awareness, change public attitudes and develop strategies to prevent mental illness'. It is essential that mental

health strategies encompass the roles of promotion and prevention, and that purchasers of mental health services ensure that these roles are embraced by providers. Particular attention should be paid to

- links between local and national health promotion activities and local service provision

- positive targeting of appropriate services on areas of social deprivation

- linking the purchasing of mental health services to wider health gain policies and activities.

2 A COMPREHENSIVE MENTAL HEALTH SERVICE

Each locality must have a network of services which offer a response to those with mental health problems. The routes to and through these services must be clearly signposted. The components considered to be essential to the development of a comprehensive mental health service are highlighted below. This is followed by an exploration of key issues to be addressed in commissioning decisions

- primary care provision
- assessment and care management
- emergency responses
- crisis services
- hospital and community places
- respite arrangements
- assertive outreach services
- information and advice
- opportunities for day activity

COMMUNITY PROVISION

General Practitioners

Primary health care services, especially GPs, are the starting point for most people with a mental health problem. They underpin other services and are the main access route to other health services. They should not, however, be the only route.

Some 90 per cent of all people with mental health problems coming to their GP are treated within the primary care setting, perhaps with an input, where available, from a clinical psychologist, counsellor or CPN arranged by the GP. Less than 10 per cent of patients are referred to secondary psychiatric services.

Many GPs state they would value more support for their role from additional community-based resources or from hospital-based services providing outreach or backup support for the GP role. This has been found in other parts of the UK to be especially helpful for GPs when working with the small population of patients who have a high level of need. A key feature is a clear route for referral for those individuals requiring more intensive support and immediate access to crisis services.

At the same time, the network of community-based and hospital-based services should integrate with GP services. The level and range of additional community resources is likely to include staff and practical services to complement and backup the GP's role in caring for people with mental health problems. In particular, projects to support people moving from hospitals to the community - such as housing and related support services - should take on much of the day-to-day care for this particular group, with an agreed input from specific mental health services and appropriate liaison with local GPs.

The arrangements for planning and commissioning services should include participation by GPs, including fundholder GPs, especially for local services. It is likely that this will involve GPs working alongside staff from social work and housing departments and other interests in the public, voluntary and private sectors, as well as the more traditional links with NHS Trusts and hospital-based health staff. Financial arrangements to enable the participation of GPs need to be considered.

In addition there may be further information, training and professional support for GPs as part of the general development of mental health services, see below.

R2 Strategic commissioners need to be alert to the impact of individual GP commissioning decisions and to monitor their impact.

Community Psychiatric Nurses

There is considerable variation in the current deployment of CPN skills. In *Finding a Place : A Review of Mental Health Services for Adults* , the Audit Commission (1994) highlighted the drift of CPNs from working with those with serious and long-term mental health problems. There was little evidence of those in this group being seen more often or featuring on restricted case loads. One quarter of CPNs were reported as having no-one with schizophrenia on their case load. There needs to be more careful targeting of the skills of the CPN, not least because they have a key role to play in the effective operation of the Care Programme approach. Where particular modes of working are established, for example with individuals with anxiety disorders, this should not lead to the neglect of those with serious long-term problems.

R3 Commissioners should specify and monitor the case mix of CPNs, with the aim of focusing on those with more severe mental health problems. Adequate incentives, training and support should be given.

Other primary health care

For all members of the primary health care team it is essential that decisions on the skills to be deployed result from an identification of the needs to be addressed. Psychologists and others with a range of counselling skills are required to respond to a need for resources in this area identified both by GPs and by service users.

Consideration should also be given to the employment of less highly trained personnel as community support workers to assist both with the day-to-day living support of those with long-term mental health problems and in meeting the needs of those whose problems are of less severity. Such workers could be attached to a day centre or to supported accommodation and are a possibility for specification in resource transfer. It is important that community support workers receive appropriate training, know when and how to access other resources, and themselves are in receipt of supervision and support. They can play a key role in preventive work. Commissioners should be alert to the possibilities of collaboration with social work agencies on more innovative responses, for example use of a community development approach.

R4 Commissioners need to ensure that all members of the primary care team are clear of their own role with regard to individuals with mental health problems, with clear protocols in place to ensure that those in greatest need gain access to more specialised services.

R5 The employment of community support workers meets an essential need and allows more appropriate targeting of other skills. Their work must be carefully integrated.

Psychiatric Services

The shift of psychiatry from the institutional base to the community needs to be maintained, with an increasing emphasis on psycho-social models of care. All referrals from the GP to psychiatric services should be seen in the first instance within a community setting. Mechanisms must be in place to ensure communication between the psychiatrist and the primary health care team. Where the only provision is an out-patient clinic held on health centre premises there is a danger of minimal contact. More direct consultation models where GP and psychiatrist discuss individual patients or where the psychiatrist attends primary care meetings prior to seeing selected patients will lead to greater integration. Psychiatric services need to be resourced adequately to enable such collaboration. The organisation of psychiatric services on a sectoral basis offers opportunities for improved communication and continuity; it should be sufficiently flexible to ensure that individuals are not disadvantaged, for example those who are highly mobile.

R6 Psychiatry must be a comprehensive, integrated service which transcends the hospital / community divide and is sector based. All initial referrals should be seen at a community base.

Team organisation

These different elements of community health provision, together with psychology, social work and other professional agencies, can be organised in varying ways. Key is the extent to which different components of the service are integrated within a team structure, and the extent to which any such team is specific to individuals with mental health problems. At one end of the spectrum is the generic primary health care team; at the other the community mental health team. Ovretveit (1993) highlights the key components of effective teamwork : a manager or management group responsible for team performance, team accountability reviews, a defined team leader position, a team operational policy and a team base. While the model of team structure to be adopted for any locality must be sensitive to local factors, for example the concentration of population, it is essential that these key elements are incorporated. Weaknesses in the community mental health team model in the past can be ascribed in part to the absence of strategic management. Moreover the distinction between operational and professional management needs to be clear. If a team structure is adopted, it is important that the time implications in terms of direct contact with service users are recognised.

The community mental health team has been subject to considerable scrutiny as a model for comprehensive service delivery (Patmore and Weaver, 1991; Onyett et al, 1994 and 1995). The objective of providing a comprehensive service can have undesired side effects. As with CPN services, a continuing danger is that resources are diverted to the less dependent at the expense of those with serious mental health problems. It is essential that effective screening and targeting mechanisms operate to ensure that the needs of this group are adequately met. The optimum arrangements appear to be referral from a wide range of sources followed by careful selection before acceptance onto the team's caseload.

All community mental health teams should operate on a multi-disciplinary and multi-agency basis. They should thus address the spectrum of health and social care needs and should be involved in the co-ordination of the range of service responses appropriate to the needs of individuals with mental health problems. There is some suggestion that teams may focus on the assessment phase at the expense of the longer term response. There is also evidence of a danger of fragmentation when essential team members are only present on a part-time and intermittent basis, reducing the effectiveness of the team in providing continuous community support.

In reality, community mental health teams overlap in varying ways with the primary care team. Clear specification of the linkages and responsibilities of each professional group is essential. There is evidence that location within the primary health care setting reduces the emphasis on those with serious long-term mental health problems (Jackson et al, 1993). There is the same danger when, as most frequently, the community mental health team is based in a community mental

health centre. As highlighted above, the mechanism for integration of the community psychiatry input is crucial.

The presence of a community mental health team should enhance the opportunity for the delivery of home-based treatment, demonstrated effective in the controlled trials conducted by Muijen and colleagues (1992), and should provide the base for what is increasingly termed assertive outreach (see below). An alternative to the team model, although with less evaluative evidence, is one developed around networks. In developing such an arrangement, wherever possible the principles outlined for the team structure should be adhered to.

R7 CMHTs should be clear that their priority user group is the individual with serious long-term mental health problems. Eligibility criteria should be widely publicised and there should be an effective gatekeeping system.

R8 CMHTs should not normally be based in primary care settings, but priorities should be agreed with the primary health care team.

R9 Each CMHT should have a manager with clear operational management responsibilities.

R10 CMHTs must have an appropriate skill mix to provide a full range of services; full-time commitment should be maximised and individual roles should be clearly defined. Services should be on offer outwith the 9 to 5 day.

Care programming and care management

Experience suggests the importance of a single person holding the key responsibility for the co-ordination of service responses for any one individual. Confusion has arisen from the simultaneous specification of the role of care management within the local authority and the promotion of the care programme approach within the health agency (North and Ritchie, 1993; Schneider, 1993; Shepherd et al, 1995). The two agencies should agree their respective roles in the implementation of a coherent mechanism as an integral part of joint planning. It is particularly important to ensure clarity as to the separation or integration of the care management role with any multidisciplinary team structure (Peck, 1994). Implementation of the care programme approach to date in Scotland has been very patchy, and the outcomes of two pilot projects promoted by the Scottish Office are awaited with interest.

R11 The confusion between the care programme and care management should be resolved. This should include clarity as to who should be included within each system.

R12 The professional background of the individual allocated as care manager should be determined according to the needs of the service user. Mechanisms should be developed to allow care managers from a range of agencies.

Emergency responses

An emergency response is needed for that small proportion of people who experience a sudden unpredictable and acute episode of illness, whether as a first occurrence or subsequently. Health commissioners need to ensure they have in place appropriate services to respond to this need. This is particularly important in the community, both for the individual concerned who needs immediate attention and also for carers and other members of the community who must have confidence that back-up is readily available. Accelerating discharge programmes should be contingent on adequate provision for the emergency situation.

This document distinguishes between an emergency and a crisis : increasingly strategies and local arrangements also make this distinction. The key distinction is that an emergency is immediate and extreme and opportunities for prevention to avoid the emergency do not exist. This contrasts with a crisis where there may be indications to the individual or their carers that a crisis episode is developing and that it may be possible to offer a more tailored response at an earlier stage. As outlined below, as far as possible developing crises will be identified and appropriate support offered, reducing the number of cases presenting as emergencies.

The emergency response is therefore required by those who have immediate and specialised needs. It should offer :

- an immediate response, wherever possible, to wherever the person is located : this may be their own home, a carer's home, or some other setting

- the response must be from someone knowledgeable about mental health problems who is able to make a reasonable on-the-spot diagnosis and who is experienced in how to deal with emergencies

- though continuity in the person who responds to the user over the emergency period may not be feasible, there should be consistency in the tone and philosophy of the response.

There has been insufficient development and evaluation of different models of service delivery in this area for there to be a recommendation of a preferred alternative. A crucial element is the commissioning arrangement for the provision of services to those taken by the police to the designated place of safety. Currently this is often the accident and emergency department and it is essential that clear protocols exist between these services and their local psychiatric service to ensure the prompt availability of specialist expertise. Outwith these circumstances, there are at least three potential approaches to responding to emergencies :

- a primary local team, as specialist as possible. The local focus of the team is attractive in providing the rapid, informed response which is a key criterion. There may, however, be difficulties in achieving the optimum number of specialist staff within a single locality

- a centralised, specialist team operating over a wider geographical area, perhaps across a number of localities. The wider area of operation may create an appropriate scale of specialist team but it is more difficult for the service to achieve the rapid response needed

- a service which is integrated with those providing other responses, such as outreach, or crisis support and operated by staff working an on-call system.

In all cases, multi-agency co-operation and co-ordination in managing the emergency responses are critical. The resourcing of the team itself could also be multi-agency, particularly from health and social work services with CPNs and Mental Health Officers. The most appropriate response is likely to be determined by the scale of demand and service patterns in each locality. There could be a role for SNAP in promoting the evaluation of alternative emergency provision.

R13 A system for immediate and skilled response to individuals in an emergency is a prerequisite for comprehensive community mental health provision. It provides an essential service to users and reassurance to carers and the public.

Crisis intervention

As suggested above, a crisis can be distinguished from an emergency by the greater degree of predictability by the user or by a carer or professional. As such, there is a potential for intervention which can prevent the need for an emergency response or the development of a more acute episode.

Currently the needs of people with mental health problems for crisis intervention are met in the main by admission to an acute ward, which seeks to offer a place of safety and sanctuary where assessment can be undertaken and follow on treatment or care arranged. This service is often offered in the absence of any alternative. However research studies and user feedback confirm that hospital care in an acute setting is, in the long term, usually a less than ideal way of responding to such a developing crisis. Future services therefore should offer choice beyond admission to an acute ward.

Responses to crisis needs must include a range of provision to meet the spectrum of need. Work by Peck and Jenkins (1992) with users and other stakeholders in a range of localities led to seven proposals for the provision of services more responsive to crisis needs.

- provision of 24-hour, 7 day a week telephone help line which would provide people in crisis with immediate advice on what to do and where to go

- establish a crisis intervention team to provide a fast, informed, appropriate and sensitive response on a 24 hour, 7 day a week basis

- create local residential crisis unit(s) to provide a place of safety and asylum for users who are in acute crisis

- enable users to get support in their own home through a period of crisis. This might be facilitated by the formation of a district community treatment team

- develop community mental health centres which provide access to professional help, 7 days a week

- attachment of skilled, professional mental health care teams to provide the counselling and advice that GPs do not have the time and/or knowledge to give

- creation of users' group and/or councils that would be able to play an active role in the monitoring, managing and planning of services, with funding for a paid advocate.

Access issues, or targeting, are particularly important in relation to crisis services. Experience has shown that crisis services can be used primarily by people experiencing social problems or who are homeless, rather than those with severe mental health problems. Services will require clear specification of the purpose, services offered and type of health and social care which the various elements of the crisis service provide, together with effective gatekeeping and monitoring by provider agencies (Smith, 1996).

These are new and relatively untested approaches to the provision of crisis services and it is likely that in the short term a mix of models will be developed. In addition, other community based mental health services should provide more intensive levels of support to users over periods of identified or potential crisis. Careful attention will need to be paid to the effectiveness and acceptability of the approaches, especially for those people whose circumstances place them at greatest risk.

R14 Services accessible in a period of crisis must be available to each locality. Access to such services needs to be carefully managed to ensure effective targeting.

Respite care

In the absence of alternative resources, hospital beds have traditionally provided a source of respite for individuals with mental health problems. This setting is inappropriate for care which is solely for respite rather then health needs, and in future such provision should be provided in the main by social care agencies. Respite care responds to the needs of both service users and carers. Ideally access

is on a planned basis, with the use of such care reducing the demand for such services in an emergency or crisis situation. Provision for such circumstances will continue, however, to be a requirement. It is therefore essential that commissioners ensure through collaborative planning that arrangements for the commissioning of respite care are in place, with resource transfer as appropriate to substitute for traditional health care provision.

The embryonic nature of current developments suggests a need for careful evaluation of a range of potential models of provision. Choice should be offered between provision of a temporary carer in the user's own home or access to community-based provision where the user can be offered accommodation and support away from their normal base. This could be within a specialist provision or in a temporary carer's home.

R15 Commissioners must ensure through collaborative planning mechanisms that individuals will be able to access a range of respite care arrangements. Although the responsibility for the majority of such provision lies with social care agencies, there should be resource transfer to reflect the traditionally health based response to this need.

Assertive outreach services

Outreach services need to be targeted at a minority of people in the community with serious long-term mental health problems, who do not engage readily with more traditional patterns of services, either because of a reluctance to accept support or because of the severity of their condition.

Distinctive features of an outreach service include :

- a proactive approach which takes the care to the individual on an assertive basis
- ready availability 24 hours a day
- continuity of support, which allows trust to develop
- flexibility in the **amount** of support provided in relation to changing individual needs, including the capacity to provide intensive support outwith hospital
- flexibility in the **type** of work undertaken with the client. This can include assistance with practical tasks
- flexibility in terms of **location,** allowing the service to follow the individual - of particular importance for those who tend to move their place of residence frequently

- the opportunity to identify at an early stage signs that a person's mental health may be deteriorating, and to take pre-emptive action

- a multidisciplinary approach to assure access to a wide range of services

- the facility to combine the provision of support with an ongoing assessment of needs and care planning

The effectiveness of the approach has been demonstrated in the outreach models developed in Wisconsin (Stein, 1993), Sydney (Hoult, 1993) and in London (Muijen et al, 1992). Such services are premised on intensive levels of staffing, one worker to ten patients in the examples outlined. The importance of separating the outreach function from crisis resolution is increasingly being recognised; while an outreach service can respond when people need more intensive support, there are indications that there also needs to be access to a designated crisis service/facility

There are variations in terms of whether the service operates on a key worker basis, or whether a client sees a different member of the team on each visit. There are examples of outreach services run by the voluntary sector as well as by statutory providers. The former is evidently likely to focus on providing emotional and practical support, and to refer individuals elsewhere for specialist intervention.

Where the outreach team contains NHS staff and is able to offer a wider range of interventions, the service may be able to act as a back-up for people who receive a basic level of support from other sources, for example supported accommodation, but from time to time need more intensive input.

As with crisis services, there is role for SNAP in exchanging information about the size and nature of the user group benefiting most from this approach, and in monitoring the development of models of practice.

R16 Provision of an assertive outreach service must be of the highest priority in order to offer continuity and consistency to individuals with enduring needs.

IN-PATIENT PROVISION

With the increasing focus on community provision, it is important that the commissioning of adequate resources for those who may need in-patient treatment is not neglected. Three main categories of need can be identified

- those who spend the majority of their time within the community but on occasion need to be admitted for acute treatment, some within a secure setting

- those who following admission require a period of inpatient rehabilitation

- a small number for whom community placement is problematic and who may require continuing care for an indefinite period

This latter group has been termed the 'new long-stay'. A national audit of patients aged 18-64 who had been in hospital for between six months and three years (Lelliott et al, 1994; Lelliott and Wing, 1994) suggests that two groups currently predominate : younger single men with schizophrenia and older married women, often with a diagnosis of affective disorder or dementia and with poor personal and social functioning.

In addition, there remain in Scotland a group of 'old long-stay' and those whose progress through rehabilitation has been slow. Although a decreasing number, hospital closure plans are likely to bring the needs of this group to the fore in the short-term, creating particular challenges for the commissioning of services. The specific issues pertaining to hospital closure are addressed below under the management of change.

Strategies need to determine locally the appropriate numbers of beds to be provided in each of the three categories identified above, reflecting in part the established relationship between the prevalence of mental health problems and social deprivation (Thornicroft et al ,1992). Targets will also depend on the provision of alternative facilities within the community, and may be modified as community provision expands, in particular the support through assertive outreach of the small group of individuals who otherwise make substantial use of in-patient care.

Given the importance of local factors of this type, it is unwise to be too prescriptive in terms of bed numbers. Nonetheless, a range of studies would suggest that working to current experience on the levels of disability that can be coped with in the community, norms for bed provision for an average population could be of the following order. All figures are per 100,000 population and exclude provision for dementia.

	beds
• **acute : intensive/secure**	6
• **acute : general**	29
• **rehabilitation**	10
• **continuing care**	6

Attention should be paid by commissioners not just to the numbers of beds but to their location and the physical environment. Facilities should be small-scale and single sex and should incorporate developing standards of good practice. Commissioners should work with providers to develop appropriate models for the delivery of good quality, efficient and effective in-patient care.

Increasing development of assertive outreach and of community based crisis services may reduce the estimates given above in the longer term. Additionally, the commissioning of secure beds may be affected by Scottish wide policy decisions that may be made in the wake of Scottish consideration of the issues reviewed in the Reed Report (1992). Commissioners may wish to consider the economies of scale

to be gained from commissioning with an adjacent Health Board or from a regional specialist provider.

Cross boundary provision should also be considered for other specialist bed provision, for example for eating disorders, for addictions and for young people (NHS Health Advisory Service, 1995a). A balance needs to be sought between the accessibility of the local service and the greater efficiency and choice offered by provision on a larger scale. The potential for staff outreach and for the release of staff to provide specialist advice across boundaries should be considered.

Whatever the facility, it is essential that arrangements for admission and discharge should be according to agreed protocols. There is increasing evidence of discharge protocols being developed, specifying the responsibilities and lines of accountability amongst the different agencies and professionals. There is less certainty, however, as to their implementation. It is important that any discharge protocols accord with the requirements of the Care Programme Approach. Similar attention needs to be given to the specification of admission protocols to ensure clarity with regard to both criteria and procedure.

R17 There should be clear specification of local bed requirements for particular groups based on an understanding of local need. Consideration should be given to cross boundary commissioning of more specialist bed provision.

INFORMATION AND ADVICE SERVICES

There are clear indications that people with mental health problems in the community need more and better information of various types to allow them to exercise choice and to maximise their independence. Carers also need information, addressing their own needs as well as those of the individual with mental health problems. This information extends beyond details of health services, to include a wide range of services and resources which may be beneficial to the individual. It should also include information on general community facilities, not only the specialist provision targeted at those with mental health problems. Likewise, there should be ready access to information for carers and professionals. GPs are often the first point of contact and they, or someone within their practice, must be able to direct individuals to appropriate information sources. This in turn requires that GPs and other professionals involved with those experiencing mental health problems themselves have access to adequate information.

Information is required on :

- mental health problems

- treatment options and implications

- mental health services

  - how to access services, including self-help groups
  - eligibility criteria
  - any cost implications for the individual
  - complaints procedures
  - what is available and from whom

- welfare benefits

  - the range of benefits available
  - eligibility of criteria
  - how to apply
  - how to appeal

- advocacy services

- housing

- opportunities in training, education and employment

- leisure and recreational facilities

Examples of existing information services include Grampian Caredata and Grampian Health Freeline, and HEBS on CD. A database of services and resources in the community is also in preparation at the Royal Edinburgh Hospital to assist people leaving hospital.

One of the main concerns of service users is the lack of information available to people coming out of hospital. The provision of accurate and up-to-date information is a substantial task, which needs to be resourced adequately. People need detailed and timely information on the resources in their particular locality. The responsibility for ensuring individuals are adequately informed of their rights and of the options available to them lies, however, with all mental health care staff, and is not the prerogative of an information service alone.

The way in which written information is presented is extremely important. It is often overlooked, for example, that people on certain types of medication may have difficulty reading small print.

It can sometimes be difficult for people with mental health problems to make use of 'mainstream' information/advice agencies. In relation to welfare benefits, for instance, there are arguments for providing specialist information and advice targeted at people with mental health problems.

The dividing lines between information giving, advice work, counselling and advocacy are not always clear. Often giving information alone is insufficient and people may need support to be enabled to use the information to full effect.

While the experience of existing information services shows that some enquiries from people with mental health problems can be dealt with by sending out standard pre-prepared material such as fact sheets, in many cases a more individualised

response is called for. This is inevitably much more time-consuming and expensive, but is valued by recipients of the service.

The relative merits and disadvantages of different types of help/advice lines need to be considered - for example the attractions of an anonymous help-line versus the familiarity of a local voice who knows of local resources. Small communities can present particular dilemmas for those who desire anonymity.

3 HEALTH, SOCIAL AND ECONOMIC NEEDS OF PARTICULAR GROUPS

As prefaced earlier, the effects of changing patterns of service provision are likely to impact differentially. There are two further aspects with implications for particular groups. Firstly, the change in service delivery may also have effects on formal service providers as care is shifted from the hospital setting to the community setting. Secondly, the potential burden on informal carers has to be recognised as they themselves will have health, social and economic needs.

Women and mental health

Although prevalence data for mental health problems is poor, research that does exist shows a marked gender difference. Women are more likely to experience affective disorders, whilst men exhibit higher rates of schizophrenia, alcohol abuse and suicide. Work in Edinburgh (Surtees et al, 1983) has shown that affective disorders are more common amongst working class women who are unemployed, and either divorced, separated or co-habiting, where up to 50% were found to satisfy the diagnostic criteria. The 1987 Health and Lifestyle Survey (Baxter, 1987) found that 33% of women as compared with 25% of men rated positive in terms of psychiatric symptoms for anxiety and depression.

These figures are reflected, where data is available, in both GP consultation rates and referral to specialist help. A study carried out by the Royal College of General Practitioners found that consultation rates by women for depression and anxiety were respectively 3 and 2.5 times greater than those for men. Women are also more likely to be referred to psychiatric hospital in general and two thirds of admissions for depression are women.

A report on Purchasing Effective Mental Health Services for Women : A Framework for Action (Williams et al, 1993) identifies a number of good practice criteria.

- consult with women who use the mental health services, with women who belong to local women's groups and committees
- acknowledge the hidden causes of women's mental health difficulties
- do not assume that all women have the same needs; address the particular needs of black women, older women and lesbians
- give priority to safety for women using mental health services
- develop alternatives to hospital admissions eg
    - small safe houses for women in crisis
    - respite care and other support services
- develop counselling services for women to address the hidden causes of women's mental health difficulties, including childhood sexual abuse

- ensure women have the option of working with, or being cared for, by women staff including eg key workers, care managers, counsellors and nurses

- ensure professional interpreting is available for ethnic minority women

- monitor service provision by gender, especially drug use and ECT

- develop personnel and training policies which support these objectives.

In addition to this list, a report on women's health in Glasgow which examines women's mental health, further identifies the need to

- establish cause specific prevalence data for mental disorder

- use this information to assess the need for current and new services aimed at responding to mental health problems and promoting women's mental health in consultation with women in the community.

In terms of local responses to women's mental health problems, there are now a number of projects which are being evaluated which are developing creative ways of providing support and enhancing well-being (GPMH, 1994). Projects in Nottingham and Glasgow have shown how women-centred group activity carried out by health visitors has reduced anxiety (Laughlin and Black, 1995). Other projects which employ a combination of community development and case-work argue their success in supporting people and particularly women, in poor areas, with mental health problems and reducing the need for hospitalisation.

Carers

Few of those discharged from long-stay care return to stay with informal carers. The role of the carer is therefore most important in relation to those who have remained for the most part in community settings, either living with family or friends or relying on them for informal support (Perring et al, 1990). Reduction of the period of acute hospitalisation may also increase demands upon informal carers.

A recent study undertaken by the Department of Public Health of Greater Glasgow Health Board in conjunction with Strathclyde Carers Forum makes a number of recommendations if the health of carers is to be protected (Hair, 1994). These are

- the important contribution made by carers needs to be recognised

- flexible respite provision tailored to individual carers' needs which ranges from short, frequent breaks to longer periods of residential respite

- provision of practical help for carers

- support for carers emotional needs, the DPH survey reporting 70% of the sample as suffering from stress

- provision of relevant information

- provision of alternatives to family care

- decisions about caring made in consultation with the carer

- recognition of the needs of ethnic minority carers

- these needs to be co-ordinated by a key worker with responsibility for carers issues

Recognition should also be given to the particular problems faced by young carers. Young carers in general are often unknown to service providers; young people caring for a patient with mental health problems are particularly vulnerable to isolation and stigma.

Black and ethnic minorities and mental health

There is very little information regarding the health of black and ethnic minority communities as health service information systems do not routinely record ethnic origin as available (Askham et al, 1995). This has now been identified as a problem by black and ethnic minority groups. The recent Health and Lifestyles Report for Black and Ethnic Minority Ethnic Groups in England by the Health Education Authority (Rudat, 1994) does however show that there is a lower rate of self reported depression and anxiety than for the UK population as a whole, although other studies show a higher than average degree of somatisation. Commissioners in Scotland need to be aware of the specific composition of the ethnic minorities in Scotland, with a particular emphasis on Chinese, Eastern Europeans and Asians.

The Black Community Care Charter produced by the National Association of Race Equality Advisors (1994) provides a framework of rights, responsibilities, care packages, contracting criteria, quality and monitoring together with checklists for action. If changing patterns of service delivery are not to reinforce current poor practice, these guidelines need to be adopted by a wider range of organisations.

Homelessness

Estimates vary as to the proportion of those who are homeless who have mental health problems but it is a substantial group (Taylor, 1992; Laing, 1993; Crockett and Spicker, 1994). (Alcohol and drug abuse are contributing factors.) It is important to note, however, that those discharged from long-term care rarely present as homeless.

Particular attention should be given to the assessment of the numbers and needs of those who are homeless within any locality, and to the identification of a lead individual with responsibility for the co-ordination of a response to homeless people who have a mental health problem. This is in accord with a Royal College of Psychiatrists Working Party (1993) which recommended that each area have a nominated consultant.

A major report from the NHS Health Advisory Service for England and Wales (1995b) has drawn upon its wide-ranging review to set out elements of good practice in providing mental health services for homeless people :

- drop-in services with self referral
- liaison and advocacy roles emphasise the requirement for an holistic approach to service commissioning and provision
- work in partnership with voluntary and community groups
- emphasis on listening - services and their staff should be perceived by users as welcoming and approachable
- effective information and publicity
- multi-agency working
- high quality clinical expertise with built-in evaluation
- outreach work and out-of-hours services.

The rural dimension

The influence of the nature of the locality on commissioning requirements, particularly in terms of rurality, has been acknowledged in a number of reports (GPMH, 1993; White, 1995). It is important, however, that planners and commissioners make the distinction between different types of rural areas, and do not assume that one tried and tested model of service can be universally applied to all rural contexts.

The particular difficulties of devising services in a rural area include :

- isolation of service users and carers, and potentially of staff
- relatively high costs of providing services to a small dispersed population
- the high visibility of mental health services in a rural setting, which can add to the stigma users may experience
- accessibility in view of poor public transport
- low level of coverage, when people may be able to have access to a day service once a week only
- obtaining information on services and resources
- the balance between specialist and generic services in a rural area, which will differ from that in an urban area

R18 There needs to be a sensitivity throughout the commissioning framework to the needs of specific groups, for example black and ethnic minorities, those with multiple disabilities, those who are homeless or live in rural areas, and those who are carers..

4 IMPLEMENTATION OF CHANGE

It is important to reiterate that provision for those being discharged from long-stay hospital beds is but a small sector of mental health activity. Nonetheless, with the expectation from NHS MEL (1993) 67 of a reduction in the order of 600 long-stay beds a year (including learning disability and dementia) until 2000, and mental health strategies starting to identify certain sites for wholescale closure, it is opportune to draw the major lessons from closure programmes elsewhere.

The most comprehensive source of data is the experience of the closure of Friern and Claybury as evaluated by the Team for the Assessment of Psychiatric Services (TAPS) under the direction of Leff. Their main recommendations to date for planners and commissioners can be summarised as follows (Leff et al, 1995) :

- A range of accommodation is required with graded staffing levels. Core and cluster arrangements allow individuals to move as needs and preferences change.
- Young, new long-stay patients should be the target of intensive rehabilitation before reprovision.
- The most socially disabled patients should not be left until last but should be mixed with more able individuals at all stages of reprovision.
- Individuals with a history of vagrancy and/or absconding should be placed in staffed homes.
- Patients likely to be difficult to place because of persistent special problems such as aggression and inappropriate sexual behaviour should be identified at an early stage. They should be given an intensive behavioural programmes tailored to their particular problems. Ideally staff should accompany the patients into their community settings. A special needs unit should cater for the continuing group of people from amongst the new long-stay who will present as 'difficult to place'.
- Elderly patients with functional psychoses should be transferred from hospital to community setting as soon as possible to prevent further deterioration of behaviour and cognitive function. Their care should not be combined with that of individuals with dementia.
- Psychiatric hospital staff who are sympathetic to reprovision should be recruited as 'product champions'.
- Commissioners should involve users and carers in service specifications in order to develop services responsive to users' needs.
- Central co-ordination is required to integrate planning work with providers, local authorities, users, carers, housing associations and other non-statutory agencies. Overall accountability should remain with health authorities, with co-ordination also required at area (strategic) and case (tactical) level.

- Facilities should be developed for structured and unstructured day activities, including work schemes.

- The health and local authority, voluntary and private sectors are not equally good at providing effective and cost-effective care for every former hospital patient. Careful planning and discussion is needed to ensure the appropriate targeting of resources from across the sectors on different types and levels of need.

- Better information on providers, on commissioners' intentions and on users' needs is necessary. An information campaign is also necessary for both hospital staff and the general public, with the function of consulting and educating as well as passing on decisions.

Hospital reprovision has a major impact not only on service users but on the staff of the institution. Opportunities exist within the community for the redeployment of individuals previously working within a hospital setting. It is essential that staff receive information and advice at an early stage, with all those affected kept fully informed as to timescales and opportunities.

Both the closure of hospitals and the move towards the contracting of services from the statutory, voluntary and community sectors will have particular effects on women's employment. A report by the Equal Opportunities Commission on the Gender Impact of Compulsory Competitive Tendering in Local Government has shown a worsening of the terms and conditions for women employees, with particularly severe effects on part-time workers and those employed on temporary contracts.

Training

An essential component for staff is the provision of retraining and other courses. In the main the provision of training focused on the response to changing patterns of service delivery tends to be episodic and poorly co-ordinated. A more comprehensive training programme is available in the form of the 60 day Mental Health Officer Training currently offered to social workers seeking MHO status. Consideration should be given to the extent to which elements of this programme could be incorporated in more general training provision on a partnership model. All training should be tailored to the local setting and should deal with the real issues specific to the particular closure. It should be offered around a model of partnership and team building. It should also address the needs of those functioning in the new roles of care manager and key worker. Retraining should be regarded as a legitimate element for bridging finance and applications made accordingly. Training also needs to be provided where care is remaining within the NHS but taking on a new focus, for example complementing or preparing for new community services.

R19 Programmes for hospital closure must include provision for the retraining of staff for community settings, with a review of the skills needed in delivering community mental health care in a multi-agency and multidisciplinary setting.. This should extend to all clinical and managerial staff. Training should be focused on the development of partnerships, the identification of local needs and on local operational issues. It should include an element for professionals on how to enable users to become involved.

5 GUIDANCE FOR COMMISSIONERS

The aim of this final section is to discuss the development of the structure and process of commissioning mental health services. The first step is to consider what represents good practice in commissioning.

What is good commissioning?

There are five important stages :

- **identifying current demand and unmet need.** Effective commissioning strategies need to be informed by accurate knowledge of the needs of the local population. A recent publication from the Social Work Services Inspectorate (1996) offers guidance on population needs assessment.

- **identifying current and potential providers.** The availability of new and innovative providers of care is a useful lever in achieving change in existing institutions. To avoid future dependence on a single source of supply, commissioners may wish to encourage new providers to develop or diversify. This may mean recognising that some early investment will be required, possibly in the form of a small grant scheme for the voluntary sector or for small groups of staff within trusts.

- **dialogue with users and carers, GPs, psychiatrists, CPNs and other relevant parties.** This is potentially the most important stage of the exercise since the objectives for the next round of contracts will be formulated and the means of achieving them discussed. Users of services also have a central role in identifying appropriate outcome measures to use in monitoring service performance. Commissioners should refer to the companion SNAP report offering guidance on this stage.

- **applying the available 'best practice' information.** The stages above should identify options for changes in the existing service. The next step is to build a picture of the costs and benefits of alternative courses of action using economic, clinical, sociological and other types of evidence. This forms a basis for decision-making rather than dictating a particular course of action.

- **setting contracts and monitoring their impact.** Based on information gathered in the above stages a contract specification can be prepared and alternative providers invited to discuss the cost and quality aspects of achieving the objectives set for care. Monitoring the outcomes of care is a crucial stage, but getting clinicians and others involved in discussing how this might be achieved, thus setting an outcomes-based agenda, may be even more important.

The following sections expand on the availability of best practice information, monitoring outcomes and the development of GP-led commissioning.

Monitoring outcomes of care

The development of commissioning suggests greater momentum to the development of a system of outcome measurement for mental health services. A

CRAG working party is due to consult on proposals in 1996, but this should not stifle local initiatives. Certain criteria should be carefully considered, however, before any experiment is attempted :

- is the measurement tool valid, reliable, and sensitive to change over time?
- does the tool provide a central role for the views of the service user and/or their carer?
- does the tool get away from clinical measures of process and start to consider things that matter to individuals such as feeling in control of their situation or functional limitations?

An external review of outcomes may be seen as a threat by clinicians and other providers. Commissioners must work hard to reassure providers that the objective is to determine how performance can be improved in the future rather than apportioning blame for past problems. Outcomes data must be seen as a basis for discussion rather than a computer-based, decision-making panacea. It should focus not solely on individual services but allow the system as a whole to be addressed in order to identify gaps and dysfunctions. Outcomes monitoring may uncover areas of the service which do not perform well because of lack of investment; commissioners must be prepared to invest rather than simply urging providers to improve.

Best practice information

Even with the best research effort possible, there will still be considerable discretion for commissioners in the light of local circumstances. However, some research findings will either address issues of considerable interest to all commissioners or will be so robust that they can be safely assumed to apply to most local circumstances. For example, the costing component of the TAPS research has recently summarised its conclusions (Leff, 1995):

- Community care in general is not cheaper than hospital care, although it may be a great deal cheaper for some people
- The eventual costs of providing community care may, to a certain extent, be predicted by characteristics assessed before people move out of hospital. Higher costs are associated with greater needs and appear to produce better outcomes in the first year after discharge.
- The costs of reprovision for 'difficult to place' patients may well be high because effective models of support have yet to be fully developed. Over time, and with experience, commissioners should be encouraging providers to develop more appropriately targeted services for this group.

The new Scottish Health Purchasing Information Centre has an important role in the collation and dissemination of information of this type but cannot cover all items of local interest. In some circumstances, therefore, commissioners may wish to commission local work.

GP-led commissioning

There have been developments in GP-led commissioning in Scotland, either through fundholding or locality commissioning schemes. What will this mean for mental health services?

Making GPs budget holders adds a financial dimension to the doctor-patient relationship which holds both opportunities and threats. It offers the potential for the GP to consult the individual, then to act as their agent in commissioning services tailored to specific needs. This is particularly attractive when considering patients with mental health problems, although it relies on GPs having the skills to recognise problems and involve patients in discussions. Another potential benefit is to develop further co-operation between primary care and community mental health services, with GPs able to provide funding for the services which seem most appropriate to a particular local situation.

While responsiveness to local circumstances is a potential advantage of GP-led commissioning it is also a weakness if the strategic overview of problems is lost. Resettlement of people from long-stay institutions into community-based care is an excellent example, involving complicated financial arrangements to facilitate investment in new services according to a timetable agreed with departments of social work, housing and so on. This suggests a role for a strategic management body in between GPs and the NHS Management Executive.

Other functions of such a body might include outcome monitoring : GPs using budgets to commission community-based mental health services combine two issues of great public sensitivity into one subject. There is no evidence that GP budget-holders respond to the inherent financial incentive to cut corners in treatment or to refuse to accept patients with particular needs onto their lists. However, the public and politicians are likely to require constant reassurance on this count; of course, GPs would be provided with outcomes information by the strategic bodies.

There may also be a residual commissioning role for services rarely encountered by GPs. For example, a typical GP may feel well-qualified to deal with direct access to counselling services or to commission extra CPN time; however they will have less experience of forensic psychiatric services and may be content to leave this responsibility to another body, overseen by a panel including GP commissioners.

R20 Boards should support the development of outcome measures and evaluation of services subject to proposals meeting methodological criteria which suggest results will be valid and generalisable. Consideration should be given as to how SNAP should co-operate with other groups to ensure that research is targeted on areas identified as priorities..

Conclusion

The commissioning of an adequate range of mental health services to meet both the needs of those transferring from long-stay institutions and the often fluctuating requirements of those long resident within community settings is a major challenge for the next decade. It is essential that the various elements which have been addressed in this guidance are drawn together within a strategic framework to ensure a comprehensive and co-ordinated response, both within and across agencies. Although there have been significant studies elsewhere, there is currently no systematic evaluation, either collectively or individually, of the impact of bed reduction policies and closure plans. This omission should be rectified.

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APPENDIX 1

ECONOMIC ASPECTS OF CHANGING PATTERNS OF MENTAL HEALTH SERVICES

Cost of mental illness

In 1986, the total cost of caring for people with psychiatric disorders cost in excess of £2,761 million, equivalent to just over £5 billion at current prices (Smith et al, 1995). The breakdown by diagnostic grouping was as follows (adapted from Table 4 of the original):

Diagnosis	Prevalence (%)	NHS cost (£ million)	Total cost (£ million)
Senile dementia	0.8	168	902
Schizophrenia	0.7	324	>975
Affective psychoses	0.8	44	?
Neurosis, including depression	10.2	?	?
Other neuroses	up to 26	233	?
Depression in old age	15.9	185	530
Personality disorder	13	61	?
Substance & alcohol misuse	12	16	?

Of the burden falling on the NHS, more than two-thirds represented care in psychiatric hospitals. This makes the reprovision of services in the community over the last decade an issue of major concern to commissioners of health services.

Assisting decision-makers

Implementing the policy of refocussing care from hospitals to the community presents commissioners with two challenges. The first is to devise a strategy or framework within which the transfer of clients and resources can take place; of necessity this is often quite aggregated in order to give an overall picture of year-on-year change. The second challenge is to develop the schemes that will allow the plan to be implemented. Commissioners will be faced with many options and models of care to choose between. The following section deals with one approach to decision-making, using economic analysis. Readers who are familiar with this approach may wish to move directly to the third section, which briefly reviews the most recent economics literature on resettlement.

Principles for making difficult decisions

Economic analysis is based on the principle that alternative courses of action should be compared in terms of their costs and benefits. It is the combination of these two elements that is crucial : neither can stand alone. Some health care professionals still believe that decisions should only take account of benefits often described as 'the best interests of the client'. This ignores the fact that there are insufficient resources to provide all the services that would benefit the population : in these circumstances, a decision that commits resources to the care of one client denies them to another client. Of course, one response to this situation is to lobby for an increase in the overall financial allocation to the NHS, but in the short-to medium-term at least cost has to be considered as part of decision-making.

On the other hand, decisions that are based on cost alone :

- ignore fundamental service objectives relating to health gain
- may simply shift costs to other agencies if the focus used for costs is narrow; and
- may be more expensive in the long-run if the cheapest option involves re-treating patients, retraining staff or replacing equipment.

This is not to say that costs are irrelevant; frequently cost data is the most reliable (or perhaps the least unreliable) information that is available. Before choosing the cheapest option there is a checklist of items the decision-maker should consider :

£££ do both estimates cover the same range of costs? for example, do they include capital charges, VAT, resource use outside the hospital, resource use outside the NHS, etc?

£££ are the services identical? Cost differences can often be explained by subtle but important differences.

£££ can differences be explained by the cheaper system working at an activity level that is closer to capacity? If it is appropriate to reduce the under-used capacity of the more expensive option then it may ultimately be cheaper.

£££ the presentation of cost data is often reassuringly precise, but is this precision spurious? A range within which costs can confidently be predicted to fall may be more helpful.

£££ what information is available about the quality of the service provided? Obviously, employing untrained staff, cutting spending on decor or training, and so on reduce costs. A less obvious factor is that economies of scale in nursing home provision mean that, other things being equal, an establishment with a large number of residents is likely to be cheaper per resident than a smaller home. However, cost savings have to be traded-off against the probable loss of domestic atmosphere implicit in a home of this size, and the likely impact on effectiveness of care, especially for people with severe mental health problems.

Economics offers a rationale for rejecting decisions based on cost alone by arguing that the more expensive option is also the best option **if** it offers extra benefits which justify the extra costs involved[1]. This will be a matter of judgement; the role of economics is to contribute a framework to the analysis leading up to this decision that is rational and open. In practice, of course, other aspects such as equity, preferences of clients, carers and the public, etc., will also be relevant to the decision..

[1]On economic efficiency grounds the cheaper option is only preferred if the benefits of each option are identical.

Economic evaluation is a framework for the comparison of alternatives. It seeks to identify all of the relevant costs and benefits of different options and, wherever possible, to measure and value these effects. It tends, therefore, towards quantitative analysis, but it is also in tune with evidence-based practice - it is not sufficient to claim that having more staff must be more beneficial. For an evaluation, a quantitative estimate of how much more benefit is required.

Some people have claimed that economics is what economists do, but it should be apparent that economics is what everybody does since we all allocate resources (such as working and leisure time, spending power) every day. Economics merely seeks to make this systematic and consistent. Having urged that economic evaluation should not be the exclusive preserve of the economist, the practice is far more complex than these simple principles suggest. This theme is discussed further at the end of the following section.

Individual evaluations

What type of information can economic evaluation provide? This section summarises the results of five studies, with the aim of highlighting the potential for this type of analysis to choose between competing alternatives.

- Adults with a serious mental illness facing the possibility of emergency psychiatric admission can be managed in the community by a multi-disciplinary team with outcomes that are, at worst, equal to those of in-patient care (Marks et al, 1994). Based on a randomised controlled trial, community-based care is cheaper for the NHS and does not involve cost-shunting to other agencies (Knapp et al, 1994a). While the authors concede that in-patient costs are high at the hospital where the trial took place, further analysis suggested that the advantage of community-based care is sufficient for the result to generalise to other geographical areas.

- Resettling elderly people with mental health problems into residential or nursing homes is cheaper with outcomes that are, at worst, equivalent to in-patient care (Knapp et al, 1994b). This conclusion is based on a 'before-and-after' comparison in a number of pilot projects. The authors acknowledge that these were small, well-funded research projects and that the results might be more difficult to reproduce under different circumstances. Nevertheless, community-based care was half the cost of in-patient care, hence generalising the finding seems reasonable.

- An outreach team, consisting of an enhanced psychiatric nursing service to support and treat individuals who are hard to reach for other services, costs about £486 per week (Beecham, 1994). On average staff only spend about one hour per week with clients, but this is likely to be the only health service contact these people have. No systematic comparison of outcomes with and without the service is available but this group previously relied on crisis admission for care; it is implied, therefore, that outcomes will have improved although there is no data to establish this.

- Working jointly with a local housing association, elderly mentally ill patients were resettled into 24-bedded units intended to be 'homes-for-life' (Beecham, 1994). Up to 18 full-time staff provided one-to-one support for a target of 25 hours per

week. At up to £950 per week, the scheme was more expensive than the previous in-patient care for these people but some substantial improvements in outcome (especially activities and interpersonal interactions) were noted.

- On discharge from hospital, people with psychoses can either be offered routine out-patient visits and time-limited involvement with the community support team or the team can be re-organised to offer intensive support with CPNs as case-managers for individual clients. Based on a randomised trial, the outcomes for each were equivalent but the intensive support service resulted in lower costs (McCrone et al, 1994). While the trial took place in inner London, the re-organisation took place without special training or extra resources; this suggests the results may generalise to other areas.

In summary, economic evaluations to date have tended to support a policy of resettling former in-patients in the community. Such evaluation results are helpful for commissioners and providers alike; however, there are three issues which are not resolved:

i) due to the lack of coverage of existing evaluations or their perceived lack of relevance to the local situation commissioners may wish to conduct local evaluations;

ii) individual studies do not address the question of which potential investments across the whole range of reprovision options is the best value-for-money; and

iii) most evaluations are based on the assumption that savings on hospital care as a result of reprovision can be realised, but the means of achieving this are not discussed.

These are tackled in the following three sections.

Gaps in economics information available

Commissioners may wish to undertake their own evaluations. There are two reasons for this. Firstly, the coverage of evaluation information is patchy. Many studies to date have compared hospital care with community-based services, but the issue concerning many commissioners is *what type* of community-based service to commission. For example, an earlier section refers to a number of potential services for crisis intervention, yet no evaluations have compared different mixes of these services to identify the most economically efficient. Such information will start to emerge but commissioners may well have to take decisions before a fuller picture emerges, requiring information on costs and benefits as an input. Secondly, the existing studies may be thought irrelevant to the local situation. The most obvious example would be trying to apply results from a clinical trial in inner London to day-to-day practice in rural Scotland.

In general, there is good agreement amongst economists about the fundamental principles of an evaluation; however, the application of these principles to any given field throws up its own problems. In the evaluation of mental health services, some of the issues include:

- identification and measurement of benefits - how are the benefits of mental health services to be defined, and by whom? is the commissioner concerned with a narrow view of benefit (confined to the client alone) or a broad view taking account of carers, neighbours, etc.? if a health status measure is to be used, does it meet statistical criteria of validity, reliability and acceptability[2]?

- identification of costs - are commissioners taking a narrow view of costs (NHS impact only) or a broad view (costs to other agencies, costs to client and carers)? If the broad view is taken, should all costs count equally - is it acceptable to include £1 of cost as of equal value no matter who incurs it? How should hospital savings be valued - would commissioners prefer Knapp's long-term view which uses the average cost per in-patient, or is the short-term view of only including variable costs more relevant to the decision to be taken?

- uncertainty - given the size of the shift in the focus of services and the novelty of many reprovision schemes, there is considerable uncertainty as to the costs and effects of some options. Results estimated using a set of baseline assumptions should thus be assessed for robustness: if the assumptions used are in error by (say) 10% will this affect the conclusion reached?

Many of these problems require judgement from the commissioner: economic evaluation is thus not so much a science as a framework for thought. It can be time-consuming but it can also be helpful in thinking through an issue in a methodical and rational way. Local evaluations may assist all parties in reaching a common understanding of the value of services commissioned and the logic underlying decisions. This is not the place for an extensive discussion; interested readers are referred to the volume edited by Knapp (1995).

Broad comparisons of value-for-money

The second problem discussed above is that, while a service might appear cost-effective relative to the alternative, it is not necessarily cost-effective compared with other uses of the resources. For example, it costs £486 per week for an outreach support team according to one of the studies cited above but is this the best use of the available budget? What benefits could be obtained by spending it differently?

In the acute health care sector, procedures have been compared in a table showing their cost-to-benefit ratios; would commissioners find a comparable 'league table' for mental health services of assistance in determining investments? The potential advantages of a guide to 'best buys' are obvious. Supposing a series of economic evaluations showed that the cost per unit of benefit was:

£100 for service A
£1,000 for service B
£10,000 for service C

For every unit of benefit from C, 100 units could be obtained from service A. Maximising benefits from the available budget suggests A is a better investment, although other factors may also be relevant. Advocates argue that evaluation will

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[2]That a measure is widely used in day-to-day practice or in the literature is not sufficient to establish these criteria have been satisfied!

lead to a systematic working through of issues, considering all alternatives and quantifying benefits wherever possible.

The principal methodological problem is the definition of what is meant by a unit of benefit. In the acute field, the Quality-Adjusted Life-Year weights remaining life expectancy by a factor which reflects the degree of disability and physical distress suffered in that time. While these are generally thought to be the principal dimensions of illness relevant to the acute sector, there are gaps: maternity services (including infertility treatment) and aspects of acute care which offer reassurance to anxious patients are examples. Priority services have different objectives: in care of older people autonomy, maintenance of identity and of dignity might be more important (Donaldson et al, 1988). Research has shown that the standard QALY measure is insensitive to meaningful changes in such patients' condition (Wilkinson, 1992; Chisholm et al, 1995).

The *existing* tool is, therefore, unlikely to be useful for mental health services; however, any alternative approach which could provide the weighting to reflect quality-of-life offers a means to the same end. The key aspect is that a small number of broad service objectives can be defined such that a generic unit of benefit can be constructed.

Another problem is the endpoint for the weighting scale to make the quality adjustment. In the acute sector, this ranges from absence of disability and physical distress (the best state achievable) to death (a reference point only, since states worse than death are possible). It is not clear that absence of (say) social disability and mental distress is the equivalent in mental health care. Mental illness is often a long-term condition, with periods of good health broken by brief and intermittent acute episodes or prolonged periods of some disablement. This makes it difficult to generalise a value for quality-of-life in any given period.

Economists are only just starting to grapple with these issues. An interesting alternative to awaiting academic research would be to conduct a very rapid comparison of a range of alternatives. The necessary ingredients would be access to expert opinion capable of estimating the benefits of treatment in terms of the changes in quality of life, including a rough assessment of utility.

Reallocating resources

Two approaches have been adopted by economists to help inform this process. The first involves a detailed modelling of the cost structure of a long-stay hospital with the aim of estimating how costs change with different capacities and activity levels (see for example, Haycox and Wright, 1983). While the internal market has assisted in one sense by strengthening incentives to understand cost structures, it has also placed much of the information in the hands of providers. If the modelling approach is adopted, it must be collaborative and cannot be achieved by commissioners alone. Another point to note is that there is nothing which makes this work the preserve of the economist; the main requirements are numeracy and the ability to unpick the structure of a complex organisation.

Another approach is to predict the costs of reprovision based on the experience of earlier cohorts, as in the TAPS[3] project in north London (Knapp et al, 1990; 1993). This retrospective analysis used information that would have been available at discharge from the institution to predict subsequent costs in the community. There are obvious reasons for supposing that the early cohorts will be untypical of the more general experience of resettlement. On the one hand, clients may be especially suitable for resettlement, while on the other their care may involve considerable investment to build up the infrastructure in the community.

The TAPS project concentrated on factors that would be observable prior to a client's resettlement. The best predictors of community costs for individuals were:

- gender (males tend to be more expensive, especially if they have few social contacts)

- proportion of life spent in hospital

- score on Social Behaviour Scale

While other factors were also significant, their small coefficient in the regression equation implies that their impact is not large except in extreme cases. Overall, 33% of the variation in community costs between individuals was explained, a creditable performance for cross sectional data.

Thus while economics cannot contribute directly to the management task of switching from hospital to community based services it can still offer useful planning information.

Conclusion

Commissioners attempting to commission services that maximise benefits from the available budget may find it helpful to consider evidence from economic evaluations. The quality of existing studies is high but coverage is limited; to cover the information gaps, commissioners may wish to undertake local evaluations. This may prove a valuable thought process in itself, but also raises the possibility of a means of comparing the results from different evaluations in order to identify 'best buys' in commissioning services.

[3]Team for the Assessment of Psychiatric Services