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Editorial

Transforming mental health services†

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Summary
Specialist teams have had a major impact on service delivery in England. Their effectiveness is now being questioned and integrated teams are developing in some areas. However, the gains made in terms of improved access, engagement and early intervention must not be lost.

Declaration of interest
None.

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The introduction of specialist teams as part of the National Health Service (NHS) Plan in 2000 was controversial and debate has continued as to their cost-effectiveness. Nevertheless, early intervention, assertive outreach and crisis resolution and home treatment (CRHT) have been embedded into services and transformed the way they have been delivered. But have they transformed patient and carer experience and outcomes?

The Patient Survey results[1] have shown that people using mental health services are generally very positive about the staff they had seen, although they are rather less positive about in-patient admission. Similarly, recent statistical comparisons provide a broadly positive commentary on change since the NHS Plan and set a context for assessment of individual components of it.[2] The number of people in contact with services since 2004–05 has risen, with a decreasing proportion spending time in hospital: from 10% in 2004–05 to 8% in 2008–09. There has been a 17% decrease in admissions, although there has been a rise in the proportion of patients who were formally detained during the year from 24% to 32%. As a result, acute beds have closed, with average daily occupied beds reducing from 23 809 to 21 107. Since 2004–05, admissions under 30 days have fallen by 13%. As the NHS Information Centre report surmised, 'this could show the impact of crisis resolution teams on the number of people being admitted for shorter stays'.[2]

Impact of CRHT teams

However, Jacobs & Barrenho[3] have assessed the specific effects of the introduction of CRHTs on admission rates and have not shown any definite impact on these. It is, however, difficult to isolate the effects of one component of a service from the other changes occurring, and other CRHT functions were not considered such as prevention of 'inappropriate admissions', reduction in length of stay by early discharge, effects on out-of-area placements, positive effects on other parts of the service and on staff, e.g. the beneficial effects of not being distracted or even extracted from out-patient clinics, or on the quality of care provided. Patients and carers have regularly voiced the need for the 24-hour support which has been made available by CRHTs, although this is often restricted to those currently under the teams.

Jacobs & Barrenho have used methodology which seems as robust for their purpose as is possible with such policy evaluations. So is this, again, a problem with translation from research to practice? There may be an issue regarding fidelity to the original guidance. A definitive UK trial[4] did show benefits but the evidence overall has never been very strong.[5] The recent briefing by the Audit Commission[6] highlighted differences in admission rates and lengths of stay across the country, poor targeting by CRHTs of those with psychosis and variable involvement of teams in gate-keeping. There is an inherent inconsistency in describing CRHTs as crisis resolution *and* home treatment teams and there has been variation in the intensity of home support; brief visits and telephone support more frequent in some services compared with extended care to provide management of agitation and relief to carers in others. Most significant in relation to overall lengths of stay has been the absence of any change in stays over 3 months. In 2008–09, 5% of individuals had been in hospital for over a year – unchanged since 2004–05.[2] Similarly, the proportion in hospital for 3 months to 1 year (16%) has changed very little.[2] Limitations on availability of social care have been significant as a factor in delayed discharge'. Mental health services were not made subject to the provisions of the Community Care (Delayed Discharges) Act 2003, which lead to financial penalties on local authorities where lack of such care is delaying discharge. One billion pounds is soon to be transferred from the NHS to the social care budget and this might be an appropriate time to consider removing that exemption.

Funding issues

The policy overall has been intentionally inflexible, which has led to the imposition of a specific functional model on a range of community services. The advantage has been that teams based on the available evidence have been developed and established across England. Funding for this specific purpose has been spent as intended without being siphoned off by commissioners and providers for other purposes. Governments want to know what public money is being spent on and, increasingly, see evidence that it is achieving positive results. This means using routine clinical and patient-rated outcome measures (e.g. DIALOG[7]). If they don't have such information, they can and, in the near future, will cut funding: it is a lot easier to remove a percentage from a 'block' contract than cut from specific patient groups. The introduction of Payment by Results[8] has to be seen in this context as a method of determining how the £1 in £7 of NHS funding that is spent on mental health services is achieving value for money. However, the system currently proposed is using 'clusters' based on an

†See pp. 71–76, this issue.

unvalidated extension of the Health of the Nation Outcome Scales, which lacks a relationship to research evidence and guidelines and is of unknown reliability. Diagnosis has been prematurely jettisoned when use of a combination of broad categories[9] (e.g. bipolar, psychotic and depressive disorders) and care pathways (e.g. acute, community – care programme approach and non-care programme approach) which link to the existing evidence base could provide clinically meaningful and relatively homogeneous groupings for costing.

Integration of teams

The disadvantage of the policy is the lack of flexibility in the matching of resources to need, for example multipurpose teams may be more appropriate in dispersed rural communities compared with inner cities. Integration of teams is occurring in some areas but there is a serious danger that in achieving economies of scale, the gains that have been found with the teams will be lost, i.e. improved engagement of patients with assertive outreach[10] and both the economic[11] and clinical benefits demonstrated for early intervention.[12] There also needs to be consideration of other interfaces with traditional teams for child and adolescent, old age, forensic and rehabilitation patients and possibilities for integration or re-alignment of these (e.g. extending CRHT functions to other age groups).

Care pathways

The models of intervention underpinning teams' philosophies of care and the role of evidence-based practice are often unclear. Although the time-scales for intervention differ with the various teams (shorter with CRHTs compared with assertive outreach teams), relevant National Institute for Health and Clinical Excellence interventions should still be offered, for example crisis plans and psychological interventions for families and individuals, especially for psychosis and borderline personality disorder. The discontinuity involved in a system with multiple different teams can mean that patient care pathways are disjointed and relevant interventions not even considered. As services are again transformed, integrated care pathways and outcome measurement are central to guiding this process, with the internet and hyperlinks now available to effectively organise the necessary supporting information.[13] These pathways can act by empowering service users, carers, staff and commissioners, guiding them through a complex system, which need not be chaotic, making choice and effective treatment available, driving necessary change while improving efficiency and quality.

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