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# Service transformation

## Lessons from mental health



### Key messages

- It is important to have an honest, powerful, well-communicated narrative that goes beyond technical and clinical issues. This is more likely to succeed where there are ethical and emotional arguments shared with key stakeholder groups and where those groups are engaged with the change process.
- Organisations responsible for both the existing and the new services may find it easier to implement the workforce and financial implications of change.
- Vertical integration of the whole range of care from inpatient provision to social care support is important and must be actively managed. This includes integration of expertise from independent and voluntary sector organisations.
- Simply moving the location of care without redesigning is not enough – existing services should not simply be replicated in new settings.
- While nationally and internationally developed models are useful, choice of any particular model should be driven by local need, allowing flexibility for local providers to innovate. Any new model should have clear objectives and be properly evaluated.
- It is important to invest in new capacity before existing capacity can be closed, which requires a system-wide approach to change. New community-based models may not produce large savings.
- Complex system changes produce unexpected results, new demands and a different set of risks. New demands will emerge in response to new services.
- It is important to invest in helping staff across organisations to develop and change roles, and learn new skills and ways of working; particular attention should be given to the opportunities for team approaches and care co-ordination.
- Change requires high-quality and stable leadership that supports the needs of stakeholders and is consistent with the direction of change. National and local mechanisms should be developed to invest in shared learning between organisations and to support change.

- Change on this scale will not follow a linear process and may take several years to achieve. This should be reflected in planning processes.

## Introduction

The development of community-based alternatives to hospital care has been a long-standing policy objective in the United Kingdom and elsewhere. Despite a widespread consensus that enhanced forms of primary and community care are necessary to meet the challenge of an ageing population with rising rates of long-term conditions, there has been limited success so far in bringing about large-scale change.

Mental health services have gone through a radical transformation over the past 30 years – perhaps more so than any other part of the health system. A model of acute and long-term care based on large institutions has been replaced by one in which most care is being provided in community settings by multidisciplinary mental health teams. These teams support most people in their own homes but have access to specialist hospital units for acute admissions and smaller residential units for those requiring long-term care.

The process, however, has not been simple. The closure of the asylum system overall was a success and no further large institutions exist. But the model of community care has undergone a number of changes in light of emerging knowledge and developments in the social context of mental health care provision.

From the initial model of community care, it was recognised that a proportion of patients required more support than the original teams could provide. The concept of mental illness and perception of needs has also evolved. Traditionally thought to be a life-long debilitating illness, there has been an increasing awareness of the roles that people with mental health problems can, and do, play in society and the potential they have for recovery. New models of care co-ordination and service delivery have supported these changes, thereby developing a system of service delivery that incorporates the capacity to intervene early and focus on managing illness within the wider context of achieving a fulfilling life. These later developments in care are a significant move away from a system in which the needs of patients were determined and met by the system, towards one in which patients are given an increasing role in self-determination and where the service user's experience of care is part of evaluating success.

Some commentators have drawn parallels between the process of transformation in mental health services and what is now desired in other parts of the health system. However, there has been little detailed exploration of how far that comparison is valid or of the lessons that can be learnt.

This report takes mental health services for adults in England as a case study and examines the relevance of this experience to current policy. It focuses on understanding the dramatic changes to mental health services and the factors that enabled that change to happen.

The report is based on two workshops held in July 2013 and supplemented by evidence from a review of published literature. Workshop participants included individuals who had been personally involved in supporting the transition from institutional to community-based care, service users and carers who lived through the changes, and professionals currently involved in attempts to develop out-of-hospital care in other clinical areas.

## Mental health services: a brief history of transformation

The transformation of mental health services stretches back over many years but took place in earnest from the 1980s onwards. There were three distinct phases to the change process:

- a period of increasingly rapid de-institutionalisation
- development of comprehensive models of care including care co-ordination and community service systems
- diversification of service provision and delivery to meet local needs.

### Phase one: period of de-institutionalisation

Until the 18th century, care of people with mental health problems was mainly a family and community responsibility. The industrial revolution saw the development of a more institutional approach, which evolved still further in the 19th century. During that time, recurring scandals in private ‘madhouses’ combined with the increasing inability of the workhouses to manage people with mental health problems led to the building of a network of publicly owned county asylums. Care centred on these specialised hospitals, set apart from mainstream medicine (Murphy 1991). By 1954 there were 154,000 patients in these institutions, which were overcrowded and underfunded. They contained 40 per cent of the NHS inpatient beds but received only 20 per cent of the hospital budget (Goodwin 1997).

The second half of the 20th century saw a fundamental shift in the way people with mental health problems were cared for. Advances in psychiatry, including the introduction of antipsychotic drugs and mood stabilisers during the late 1950s, allowed more people to be treated in the community, and outpatient clinic attendances increased from virtually zero in 1930 to 144,000 in 1959 (Lester and Glasby 2010). Furthermore, in a reflection of changing social attitudes, including a greater emphasis on human rights and advances in social science and philosophy, the 1959 Mental Health Act stated that people who were deemed sane but labelled ‘morally defective’ due to their unconventional behaviour could no longer be admitted to an asylum. The Act also identified the community as the most appropriate place of care for people with mental health problems. In 1961 the then Health Minister Enoch Powell further underlined the policy of closure in his ‘water tower’ speech, which announced his intention to halve the number of beds for people with mental health problems. This speech was followed by the 1962 Hospital Plan, which advanced a vision for developing acute inpatient care units for people with mental health problems on district general hospital sites and proposed that local authorities should provide a range of services to support people in the community. A series of investigations into the ill-treatment of patients in asylums (DHSS 1969, 1971, 1972) gave further impetus to moves to close these remote institutions.

By 1974 there were 100,000 residents in asylums, 50,000 fewer than 20 years previously. The majority of these residents had been there a long time and were now elderly, with a mix of mental and physical health problems. The financial pressures facing the country during this period had resulted in very few community services being developed (Barham 1997) and despite the significant reductions in inpatient numbers, the first large-scale closures did not take place until the late 1980s.

The majority of the long-stay residents were moved out of asylums into residential accommodation provided by the private and voluntary sectors, which largely offered the ‘community-based’ institutional care. Acute inpatient care was often moved to smaller mental health units on district general hospital sites, on the assumption that the number of beds required would be reduced by new community interventions being planned. Specific funding mechanisms were developed around individuals, helping to enable change. A ‘dowry’ system was developed in the 1980s to counteract the difficulties of resources still being tied up in hospital care for the remaining long-stay patients (Hallam 1998). It allowed money to move in a protected way from hospital to local authority budgets and was usually only paid on the permanent closure of a bed. For the earliest patients this was a capitated amount. Social security payments were also used initially,

as they were available to people living in the community to pay for long-term residential care (but they were not available for long-stay hospital patients' needs). However, the NHS and Community Care Act in 1990 closed this avenue and transferred the care elements of social security payments to local authorities. Finally, a joint finance initiative was introduced to pay for the provision of social care for people who otherwise would be the responsibility of the NHS.

## Phase two: developing comprehensive models of care in the community

As community service provision expanded, a single model of care based on the establishment of community mental health teams emerged. Although new accommodation was found for older people who had been long-stay residents in the asylums, there was increasing concern that the community services were failing to meet the needs of those with severe and enduring mental illness and of younger people with more recently diagnosed illness. A series of reports into the inadequacy of community care services led to the introduction of the care programme approach in 1990 and the NHS and Community Care Act (1990). The care programme approach provided a framework for effective mental health care for people with severe mental health problems, while the Act redefined the role of health authorities and local authorities to ensure that people were assessed for social care support and received the services they were entitled to. This was supported by the 1991 mental illness specific grant, a ring-fenced direct grant from central to local government that could specifically be used to purchase necessary social care services and further develop services supporting people with mental health problems in the community (Dean and Freeman 1994). Throughout the 1990s the numbers of large asylums closing their doors increased and by the end of the decade most had plans to close.

Further concerns emerged about the capacity and capability of the generic community mental health teams to manage people with complex mental health problems and those in acute crisis. A series of high-profile adverse incidents, in particular the killing of Jonathan Zito by Christopher Clunis in 1992, led to arguments that community care had 'failed', or had at least been inadequately implemented. This resulted in a growing policy focus on people with severe mental illness and risk management, public safety and containment.

This new phase of transformation gained fresh momentum in 1998 when mental health was identified as one of three clinical priorities by the new government. The publication of the White Paper *Modernising mental health services* (Department of Health 1998) provided a comprehensive view of the future of mental health policy, supported by £700 million of new investment over three years. This was followed in 1999 with the first national service framework (NSF) for mental health (Department of Health 1999). It set out standards in five areas of care: mental health promotion; primary care and access to services; effective services for people with severe and enduring mental illness; caring about carers; and preventing suicide.

Given the existing emphasis on managing risk, particular focus was placed on developing services for people with severe mental illness. The NSF prescribed three new service models that had emerged internationally, and which had been implemented in the United Kingdom in a limited number of localities. The NSF for mental health mandated the development of these services across England, supported by a national implementation plan, additional money and a deadline by which all trusts should have complied. The key services comprised:

- assertive outreach teams – a model of enhanced case management aimed at providing intensive support to people living in the community with complex needs

- crisis resolution and home treatment teams providing, wherever possible, time-limited enhanced support for people in the community in order to prevent admission and facilitate early discharge from hospital
- early intervention teams – a model of care co-ordination for people experiencing a first episode of psychosis.

The scale of change was unprecedented, requiring 50 early intervention teams, 335 crisis resolution teams and 220 assertive outreach teams to be established by 2004 (Department of Health 2000). Multi-agency local implementation teams were required to be set up to ensure that comprehensive mental health services were put in place, in line with the NSF. A national body, the National Institute for Mental Health in England (NIMHE), was established to oversee and support the modernisation process. A national focus, infrastructure and financial support were successful in driving wide-scale change, particularly in areas where service development had been limited or slow. Furthermore, the expected benefits of improved community care and evidence that suggested this would reduce the demand for beds led most providers to reduce their inpatient bed provision. Some providers closed beds in anticipation of the reductions in need; others closed beds in parallel with community service development or after, as a result of over-capacity.

The staff requirements of these new teams led to a substantial increase in the workforce. Work undertaken by the NIMHE and the Royal College of Psychiatrists resulted in *New ways of working* for psychiatrists (Department of Health 2005), a policy document that outlined new roles for psychiatrists in supporting multidisciplinary teams and service improvement, and a diversification of the workforce, particularly by allied health professionals. Together with the *Creating capable teams approach* best practice guidance (Department of Health 2007) these documents aimed to provide teams with a means of assessing their skill requirements in order that they could provide mental health support to professionals beyond secondary care services and ensure that ‘the right staff were doing the right jobs’. Over time this resulted in large increases in the number of clinical psychologists and support workers and in moderate increases in the number of psychiatrists and mental health nurses.

Several other national policy documents proved important for driving change. The national suicide prevention strategy (Department of Health 2002) provided a clear focus on reducing suicide rates after patients, carers and campaigning charities highlighted growing concerns about patient safety and poor therapeutic environments in acute inpatient care. The strategy provided clear guidance on how providers should modify environments to reduce risk and led to improvements in the safety of inpatient environments. The NHS Operating Framework for England (Department of Health 2006) also asked commissioners to ensure that providers were committed to reducing mixed-sex accommodation wherever possible. As a result, some of the inpatient units established in the early days of de-institutionalisation were deemed unsuitable for delivering safe inpatient care for people with mental health problems. The closure of these units led to further reductions in the number of beds, with the released funds often being used to upgrade other units or provide new facilities in smaller, purpose-built accommodation.

Another area that was put under scrutiny during this period was provision of care for black and minority ethnic groups. Emerging research showed that people from these groups were more likely to be diagnosed with mental health problems; be admitted to hospital; be subject to coercive forms of care; experience poor outcomes from treatment; or disengage from mainstream services (NIMHE 2003). However, it was the inquest into the death of David ‘Rocky’ Bennett in inpatient services and the resulting report recommendations of the inquiry into his death that formed a focal point for action (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority 2003). In particular,

it prompted providers to implement training and policy directives to meet their responsibilities under the Race Relations (Amendment) Act 2000. In some areas new services were developed specifically to meet the needs of black and minority ethnic groups.

During this period many NHS trusts became partnership trusts, where local authority social work services became formally integrated with NHS services, although this happened predominantly outside London in areas where an NHS trust and local authority provider shared coterminous boundaries. In addition to greater partnership between health and social care, services were increasingly commissioned from third sector providers, who had been developing often innovative services independently of mainstream provision that offered a choice of cost-effective specialist services. In practice, NHS trusts were the main commissioners of these services, determining both need and provision having received block contracts from commissioners to provide mental health services for a geographical population. The majority of commissioned services represented additions to the core NHS and local authority service structure.

### Phase three: developing and innovating to meet emerging needs and agendas

The NSF for mental health delivered significant improvements in service delivery for people with severe mental health problems across the country. During this period service users and carers became increasingly vocal and the membership of campaigning charities increased and broadened from the original asylum survivor movement. Services designed to intervene at the early stages of illness, focusing on helping people to manage and live with mental illness, proved to be largely successful. New evidence-based models of supported employment moved the focus beyond simply managing illness, and new services were developed to replace outdated models of care such as day hospitals.

As the newly established NSF services had time to embed, there was a growing recognition that rigid implementation of some of the prescribed service models was not appropriate to all localities and that more local flexibility was needed. As a result, a number of the NSF service models were decommissioned or restructured to meet local needs. Assertive outreach services received particular attention, as they were costly to provide yet often failed to demonstrate that they had reduced hospital admissions despite their success in engaging people with very complex needs (Firn *et al* 2013). These services had largely replaced existing rehabilitation services (resulting in a 30 per cent decrease in provision), but many individuals previously served by the latter did not meet the tight referral criteria of assertive outreach outlined in *The mental health policy implementation guide* (Department of Health 2001). This resulted in a new level of unmet need (Mountain *et al* 2009). In an effort to adapt services to local requirements and reduce system complexity and perceived inefficiencies, many providers changed the referral criteria and operating procedures of these services. In the case of crisis and home treatment, teams increasingly concentrated on existing patients and no longer provided 24-hour care, while assertive outreach staff and functions were merged into generic community mental health teams. Some trusts stopped providing these services altogether.

In recent years, national policy has become more supportive of local innovation, with an increasing emphasis on broadening access to mental health services beyond those with severe mental illness. Although improving public health, modernising primary care and mental health provision for older people and children were core standards in the NSFs, limited progress was made in these areas. One of the most influential recent policies has been the improving access to psychological therapies (IAPT) programme, which was established in 2006 and allocated funding of £33 million in the first year and £70 million each year for a further two years under the 2007 comprehensive Spending Review. The funding was subject to a public service agreement between the Department of Health and

the Treasury, and IAPT was made a priority in the NHS Operating Framework 2008/9. These services have been rolled out across England as a means of implementing National Institute for Health and Care Excellence (NICE)-approved therapies for depression and anxiety disorders.

A second area that has benefited from considerable attention is service provision for older people, and in particular for those with dementia. This was driven by the recognition that existing health and social care service provision for dementia was poor, highlighted by a number of reports and research including the National Audit of Dementia conducted by the Royal College of Psychiatrists ([Royal College of Psychiatrists 2011](#)). In addition, the increased prevalence of dementia in the population and the high costs of dementia in terms of both care and wider costs to society were deemed unsustainable. Services had focused on those in the late stages of dementia but research suggested that early diagnosis and treatment could have a significant impact. In 2009 the government produced the first national dementia strategy and an implementation plan for England. The strategy called for significant improvements in 3 key areas including early diagnosis, identifying 17 key objectives for transforming services, to be implemented at a local level over a 5-year period ([Department of Health 2009a](#)). This was supported by a commissioning pack and action plan, although commissioners have had to fund implementation up front in expectation of cost savings from reduced residential care requirements. A revised outcomes framework for dementia (Department of Health 2010) aimed to accelerate the pace of improvement, making local commissioners accountable for implementation.

In 2009, the government published *New horizons: towards a shared vision for mental health*, with priorities including: personalised services; equality; addressing stigma; and improving the physical health of people with mental health problems ([Department of Health 2009b](#)). The coalition government's approach builds on this vision. The Health and Social Care Act (2012) required the NHS to place mental health 'on a par' with physical health, and the cross-government strategy *No health without mental health* ([Department of Health 2011](#)) set out six objectives to improve the health and wellbeing of the population and outcomes for people with mental health problems, partly reflected in the NHS Outcomes Framework. Both documents provide a much broader concept of mental health, widening access and championing models of service provision that support the equitable involvement of patients in treatment, management and service provision. This approach to care delivery, as opposed to a specific model in itself, allowed individual providers to develop services in many different ways, from training programmes to better signposting for services provided by the NHS and third sector.

Acute inpatient service provision has remained a challenge. Although a handful of providers invested in new models of inpatient provision or commissioned third sector services ([Johnson et al 2009](#)), in practice most provision remains within specialised hospital services in the NHS. With more people being successfully managed in the community, the severity of illness in inpatient settings has increased and the number of acute inpatient beds has reduced. This has put pressure on providers to further improve the quality of inpatient provision, often closing more remote hospitals and drawing services together on a single site in order to increase staffing and reduce costs. However, for many providers bed capacity is no longer sufficient to meet demand, leading to an increasing number of out-of-area placements at substantial cost.

Although not strictly part of a story of developing community care out of hospitals, the role that mental health providers have played in the management of individuals in the criminal justice system should also be considered. The recognition that more than 90 per cent of prisoners have a mental health problem, and the high financial cost of incarceration, led to the development of court diversion in the 1990s. In practice this resulted in the development of specialist secure units in which treatment could be delivered ([Centre for Mental Health et al 2011](#)). However, increasing numbers of

prisoners, high running costs and limited evidence of effectiveness have drawn into question the role and value of secure care. Furthermore, with the transfer of prison health care into the NHS, many providers took up responsibility for delivering mental health care for prisons. This adds a further layer of complexity to the system of mental health service delivery. The financial pressures of running these services have had an impact on other areas of the system.

### Timeline of key events

- 1946 National Association for Mental Health (now Mind) is founded
- 1948 National Health Service Act comes into force
- 1955 Chlorpromazine appears as first antipsychotic drug
- 1957 Percy Commission states that mental health should be treated in the same way as physical health
- 1959 Mental Health Act reduces admissions to asylums through more stringent admission criteria
- 1961 Health Minister Enoch Powell's 'water tower' speech
- 1962 Hospital Plan brings in smaller, community-based hospitals
- 1971 The Medico-Psychological Association becomes the Royal College of Psychiatrists
- 1972 Whittingham Hospital Inquiry report published
- 1975 National Schizophrenia Fellowship (now Rethink) is founded
- 1983 Mental Health Act establishes the role of 'approved social worker' and imposes a duty on local social services authorities as well as health authorities to provide aftercare services
- 1986 Survivors Speak Out, a network of service user advocacy organisations, is formed
- 1986 First asylum closed
- 1990 NHS and Community Care Act introduces the purchaser/provider split in health services and outlines entitlement to a community care assessment for service users
- 1990 Care programme approach introduced as a framework for care planning in mental health services
- 1991 Mental illness specific grant introduced to support social care and community services
- 1994 Ritchie report into the killing of Jonathan Zito by Christopher Clunis highlights failures in community care
- 1998 Publication of *Modernising mental health services*
- 1999 National service framework for mental health outlines standards of care
- 2000 NHS Plan underlines new community service models, funding and timetable for implementation
- 2001 National Institute for Mental Health in England is established to support service development
- 2002 National suicide prevention strategy focuses on improving inpatient environments

- 2003 Blofeld Inquiry into the death of David 'Rocky' Bennett highlights problems with service provision for black and minority ethnic groups
- 2005 *New ways of working* published by the Royal College of Psychiatrists
- 2006 Improving access to psychological therapies programme is established
- 2009 National dementia strategy for England published together with programme of service development
- 2009 Government strategy outlined in *New horizons: towards a shared vision for mental health* prioritises equality, personalisation, stigma and physical health of people with mental health problems
- 2011 Cross-government publication *No health without mental health* introduces a new focus on public health and wellbeing, and improving outcomes

## The drivers of transformation in mental health services

The transformation of mental health services has not happened easily or consistently and was by no means a linear process. At different points there has been considerable energy and enthusiasm for change as well as resistance among some professional groups, relatives and carers. A clear message from our research and from the workshops is that a combination of factors played a key role in overcoming these barriers and in driving the transformation, although there was by no means a single driver.

The following themes emerged from our work:

- the impact of social movements and voices for change
- growing therapeutic optimism
- innovations in service delivery
- case management and care co-ordination
- changing professional roles and cultures
- financial models.

### **The impact of social movements and voices for change**

One of the important factors that enabled the transformation of mental health services was the strength of the voices of professionals, the public, service users and carers whose concerns about neglect and ill-treatment in the increasingly isolated asylums gave impetus for their closure. These concerns were raised in well-publicised reports of inquiries into proven patient abuse; in academic critiques of psychiatry by sociologists and psychiatrists questioning the underlying role of asylums (Goffman 1961); and by strong, vocal groups of service users such as the National Advocacy Group and Survivors Speak Out. The latter often critiqued services by publicising harrowing personal experiences of care (Chamberlin 1988).

Although less unified than the original movements calling for the closure of asylums, service user and carer voices have continued to impact on service transformation. The initial service user-led groups have largely dissipated, but campaigning charities such as Mind and Rethink have proved an effective mechanism for drawing together groups through their membership to create pressure for change. Often these campaigns are driven by human rights-based approaches focusing on areas of poor and inadequate care. They were particularly important in driving changes to inpatient environments and suicide rates in the early 2000s. Incidents involving people with mental health problems as both perpetrators and victims have continued to form a focal point for change, particularly when facilitated through national and local media to gain wider public

support. The NSF for mental health and the dangerous and severe personality disorder strategy are good examples of this.

### **Growing therapeutic optimism**

Admissions to psychiatric hospitals, especially to long-stay wards, had been falling since the mid-1950s. The drivers of this change are complex and interlinked, but many have suggested that an increasing optimism in the ability to treat, rather than contain, people with acute and enduring mental health problems was significant. This was coupled with the recognition that sustained long-term treatment within institutions had detrimental consequences and that effective care and rehabilitation for people with acute mental illness could be provided in the community, which in itself offered additional benefits. As a result day hospitals were developed, discharges to homes in residential areas increased, and community psychiatric nursing emerged.

The increase in the diversity, availability and perceived efficacy of anti-depressants has added to this therapeutic optimism. Guidelines have supported early use of anti-depressants and the targeting of particular groups resulted in a doubling of the average number of prescriptions in primary care from 1993 to 2004 ([Moore et al 2009](#)). In addition the development and success of early intervention for psychosis services and memory clinics prompted a refocusing of service provision on early detection and intervention in order to maintain quality of life and skills in people with severe mental illness and dementia.

### **Innovations in service delivery**

A number of innovations in service delivery have supported the transformation of mental health services. Early models of community care sought to replicate within the community the health and social care provision of asylums. For working-age adults with acute symptoms, that a model developed involved the co-ordination of care by community teams comprised of a mix of health and social care professionals with access to a specific acute admission ward and the option of self-referral in many cases.

The models deployed as part of the NSF for mental health revised this approach, moving from a generic system of provision to one in which specific needs were targeted. This offered the opportunity to provide more tailored services. The NSF drew on particular models of care that had been developed and piloted with an emerging evidence base and positive outcomes as a basis for the new system of services. Importantly two of the models, crisis intervention and assertive outreach, provided service models that fulfilled the requirement to manage risk. Additionally, they were championed by influential individuals in the United Kingdom.

Service innovations have continued in recent years. User-led and recovery-oriented community services, many of which have developed independently within the third sector, have not only highlighted the possibility of service users taking increasing control of their lives, but have provided commissioners with the potential for developing mental health provision beyond the core roles of post-NSF services that focus on patient experience. The development of psychological therapies that could be provided in a time-limited manner by relatively low-skilled staff and that demonstrated effectiveness is another example of how innovations in delivery have revolutionised service provision.

### **Case management and care co-ordination**

Case management has developed as the underpinning principle of all community mental health services in the provision of the range of care within asylums and when building on this. Early community care recognised the importance of having access to different professional groups and of the need for this access to be co-ordinated.

It became usual practice for psychiatrists and admission wards to take responsibility for all patients admitted from a specified geographic area. This aligned provision and further supported integration of care across professional and organisational boundaries. A core component of the community mental health teams tasked with co-ordination was their multidisciplinary nature, employing a range of medical, nursing and social care staff. The care programme approach further formalised this co-ordination to ensure that patients' needs were adequately assessed. Each patient received a named care co-ordinator; an individualised care plan provided a basis by which care could be sourced from a range of specialist providers. Together with the case management approach used by social services, it aimed to ensure a more seamless approach to care, avoiding the potential fragmentation and confusion that could result from service users engaging with a wide range of providers, and instead supporting a more integrated care pathway.

The strength of the case management model is clear and it remains the core of modern community mental health services. Variations have developed to address specific needs, particularly among those who require more enhanced provision. Assertive outreach employs a model of case management where the responsibility for care co-ordination is undertaken by a team, as opposed to an individual, and in which most of the care is provided by the team as opposed to being sourced more widely. This ensures that a group of people with complex needs, whom services have often found difficult to engage, receive the appropriate support.

The scope and role of case management are also evolving. Early intervention teams transformed case management from a model of illness management to a more holistic model in which teams support the needs and aspirations of young people experiencing their first episode of psychosis. In a similar vein, recovery-oriented care provision aims to move from a position in which the care co-ordinator takes the lead in managing patient care, to one in which the service user is supported to take an increasing role in identifying and managing their own health and social care needs.

### **Changing professional roles and cultures**

Professional roles and cultures have changed considerably during the course of transformation. Some developments have been welcomed in supporting the evolution of professions, but others have challenged the core notion of clinical and social care professions and in some cases this has created a clash of cultures. The closure of the long-stay institutions had a profound impact on staff as well as patients and their families. Our research suggested that the stigma attached to the large asylums meant that psychiatrists benefited from a move to services based in district general hospitals or community settings, in that it dissociated them from discredited institutions. Indeed, during the 1960s and 1970s psychiatric training was already focused on units outside asylums (Murphy 1991). Nurses also benefited. Constrained by the day-to-day rules of asylums, they were free to innovate in community services: 'for them the change has been little short of the rebirth of a profession' (King 1991). But many nursing and ancillary staff, who had often lived locally, lost more than their jobs when asylums closed. An account of the closure of Long Grove Hospital in Surrey states that for some staff, 'the closure marked the end not only of a personal era, but often a family association stretching back over generations... there was a lot of Long Grove's history locked up in its staff and some could not accept the hospital's going right to the end' (Day 1993).

Clinical leadership of community mental health teams was typically vested in consultant psychiatrists, but other professionals, including social workers, took on the day-to-day management of the teams. This team approach produced growing confidence among non-medical professionals. In 1995, a survey of community mental health teams found that most had team managers or co-ordinators from a variety of disciplines (Onyett *et al* 1995). They had day-to-day responsibility for the management of the team, even

if professionals within the team also had a clinical supervisor. There was, however, resistance from some psychiatrists because of the challenges by other professions to their traditional responsibility for admission, treatment and discharge: 'the authority of doctors has been under challenge from the other mental health professions... community care gives greater scope for independent action by other professionals' (King 1991).

The response to the requirements of the NSF and the resulting *New ways of working* policy constituted one of the largest changes in workforce and professional culture. Importantly, The *New ways of working* policy was developed in collaboration with the Royal College of Psychiatry and professional bodies representing allied professionals. This enabled teams to deliver a wider variety of care and make best use of consultants' time. However, the role of the psychiatrist primarily as consultant is argued to have led to a lack of clarity around the role, impacting detrimentally on patients, recruitment and the morale of psychiatrists (Vize *et al* 2008). More recently, the coaching aspect of recovery-oriented services further stretches the role of professionals and presents new challenges. One is the management of dual agendas for staff, whose roles in empowering patients and risk management can conflict (Gilburt *et al* 2013), while the involvement of peer workers can create tensions around expertise (Naylor *et al* 2013).

### Financial models

Most major transformations in mental health services have been accompanied by financial models that support or facilitate change. Concerns around the moral and therapeutic aspects of asylums were added to by the belief that they were financially unsustainable. This resulted in what was described as 'an unholy alliance between therapeutic radicals and fiscal conservatives' (Bachrach 1978) and led to some who were opposed to change suggesting that the real motive for change was saving money.

The slowly emptying asylums were expensive to maintain in their current state and deprived the NHS of potential sources of significant capital receipts from the sale of the estate. As part of the programme of closure, senior NHS and local government managers were required to develop a financial project plan, typically covering a five-year period, containing detailed projections of the revenue to be released from ward closures and land sales, re-investment, capital from the NHS capital programme, and new sources of funding (eg, benefits to be claimed by housing associations for discharged patients). There was a recognition that double running of costs was important if community services were going to be developed before capital receipts could be released (Mansell *et al* 2007). However, the slow pace of closure meant that significant capital receipts were not always realised, which obstructed investment to create new facilities.

A study published in 2004 found that the costs of community-based mental health care were broadly equivalent to institutional care: 'Interestingly, the evidence from cost-effectiveness studies of de-institutionalisation and the provision of community mental health teams is that the quality of care is closely related to the expenditure upon services, and overall community-based models of care are largely equivalent in cost to the services that they replace' (Thornicroft and Tansella 2004). While there is no doubt that the process of de-institutionalisation has released significant funds, a number of studies have found that rebalancing care from institutions to the community does not generate cost savings (Knapp *et al* 2011).

Other centrally available specific funding streams that have facilitated change include the mental illness specific grant to stimulate the development of innovative community services, the NHS Plan (Department of Health 2000); which provided an investment to pay for the centrally determined policies of the NSF for mental health; and IAPT.

As with the original de-institutionalisation process, providers have continued to release funds from the closure of institutional and inpatient settings, from reduced demand

and from the reconfiguration of services. Some closures have been undertaken in order to fund the improvement of existing services and development of others, while others have been in anticipation of a decrease in requirements. More recently, providers have been under increasing financial pressure as central funding decreases and expectations rise, with commissioners being asked to prioritise investment in early intervention in anticipation of future cost savings, as is the case with implementation of the dementia strategy.

## Lessons from a history of transformation

Our research identified a number of important lessons and unintended consequences of the transformation process.

### **The dangers of ‘re-institutionalisation’**

There was a danger that institutionalised professional behaviours would continue in community settings – whereby de-institutionalisation becomes re-institutionalisation, albeit in smaller institutions or in forms of community support that have not moved people on. This was the case both for those with long-term care needs, who were housed in smaller private and voluntary sector-run care homes, and also for those with acute care needs. A 2004 study of six European countries found that re-institutionalisation had occurred in the form of increased numbers of forensic beds and supported housing placements (Priebe *et al* 2005). The focus was placed on the location of the care rather than on the services that were required. One participant at the workshop said that ‘people can be receiving support from assertive outreach teams for over 10 years – this is not change, it is a different form of institutionalisation’. Another stated: ‘We changed the buildings from large asylums to small acute wards but the institutionalised culture and mind-sets of staff remained. We effectively created institutionalised community care. This is getting better but is still the case.’

### **The danger of system complexity**

The development of services focused on specific groups of individuals or needs has created a plethora of complex pathways for individuals to navigate in order to access services. In addition, while creating a system to meet a particular set of needs, it failed to account for other existing and potential areas of need. This resulted in an inflexible and unresponsive system, with people both in and outside the system confused by the various access points and referral criteria. This often led to patients being referred from service to service. Care pathways should be transparent to all stakeholders, with a clear point of access and enough flexibility to account for variations in presentation. The development of single point of access schemes in many parts of the country has been an attempt to address these issues.

### **The need to understand professional resistance to change**

It was important to understand the nature and causes of professional resistance to change. The initial champions of the change were unsympathetic to professional resistance rather than trying to understand its sources and work with them. Only later did it become apparent that some of this resistance, and in particular the concern about a reduction in acute bed numbers, may have been well-founded. There is a fine line between resolute leadership, which was undoubtedly necessary in the early days, and an overly directive approach to achieving change.

### **The need to understand the complexities of partnership working**

Participants at the workshops felt that the opportunity to fully integrate health and social care had been missed in many mental health services, despite the development

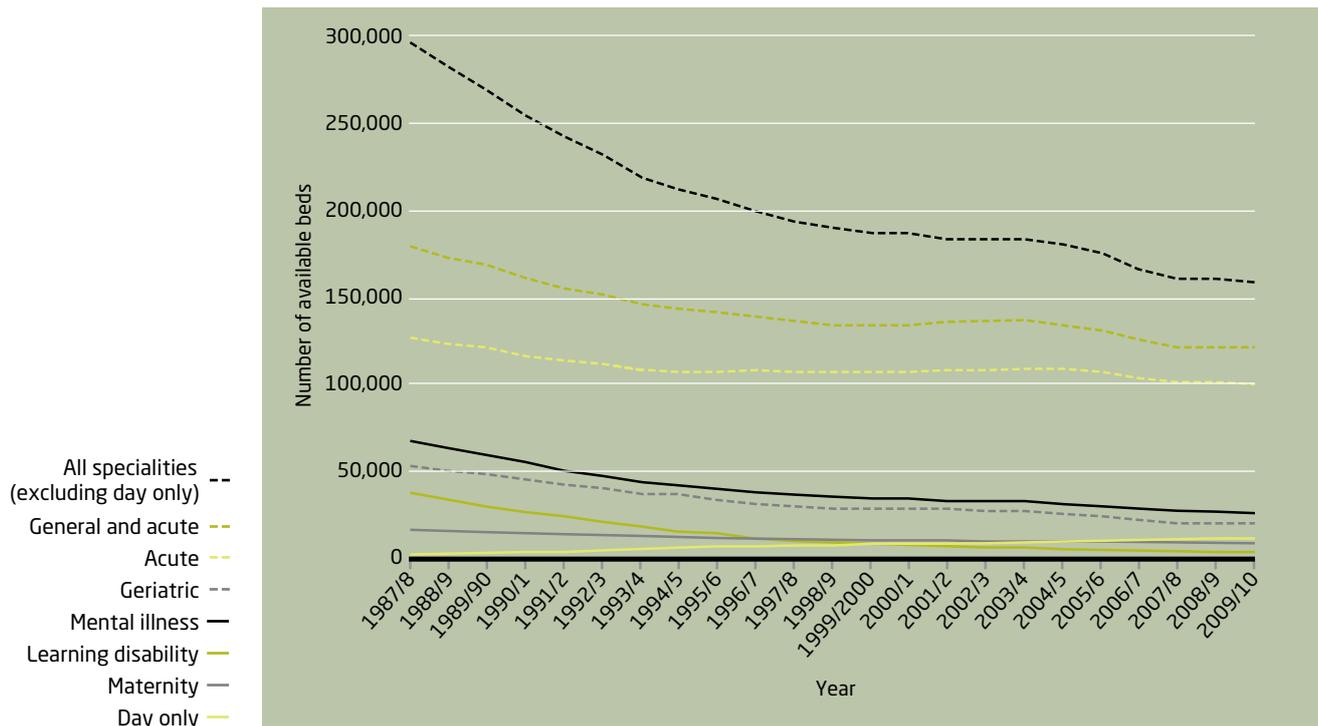
of formal partnership trusts. Although this collaboration between local authorities and NHS bodies was underwritten by section 75 agreements outlining the legal arrangements for governance and resource allocation, in practice the content was often far removed from the day-to-day practice of the teams. A lack of clarity around the professional role and governance of social workers within the teams has caused conflict between the sectors and in one extreme case has led a local authority to withdraw its social workers. Other challenges to joint working reflect more fundamental differences between health and social care provision. This includes differences in agendas and in the focus of care, from treatment and management of risk in health care to facilitating independence and personalisation in social care; and free access to care in health compared with limitations placed on social care resources by eligibility criteria. Mental health services can only be successful if housing and social care services, in particular, are working well. Some felt that where strong partnerships had existed between social care and health care organisations, they were being eroded, partly due to budget constraints and a misunderstanding of the role of the local authority, in particular the role of elected members. Joint commissioning of health and social care services, while more common in mental health services than in other parts of the health system, was also found to be complex. The changing landscape of NHS organisations responsible for commissioning (from primary care trusts to clinical commissioning groups, from strategic health authorities to local area teams) has further complicated the commissioning arrangements between local authorities on health. Some participants in the focus groups also felt that in some instances local authorities and NHS trusts were working to different agendas and priorities, with no shared strategy for commissioning or delivery.

### **The need to engage primary care**

There was a tendency to see primary care as part of the problem rather than part of the solution, and general practitioners (GPs) were often excluded from the process (Banks and Gask 2008). Champions of transformation tended to assume that GPs would prefer not to have to interact with those patients with significant mental health problems and, given the chance, would choose to redirect scarce resources (eg, community psychiatric nurses) to people with common mental health problems. This assumption led to initiatives, such as making mental health services open to self-referral – which bypassed GPs, sending the wrong message when in practice GPs deal with the overwhelming majority of patients with a mental health problem. In addition the complexity of the service system post-NSF proved challenging to navigate, impacting negatively on GPs' ability to make appropriate referrals to secondary care. A report by the Mental Health Foundation (2007) raised a number of concerns about the availability and quality of mental health care provision within primary care. The limited provision of physical health care for people with mental health problems – as raised by the report – is often highlighted as a key element in the lack of parity between physical and mental health. Furthermore, the insufficient education and training for primary care staff to deliver mental health care impacted on its prioritisation – despite the General Medical Services contract and the focus on practice-based commissioning. The lack of a national tariff for mental health services meant that there were no cost savings to be made by moving services from hospitals into primary care.

### **Unpredictable developments and unintended consequences**

One of the most notable manifestations of the unforeseen impact of transformation has been on bed numbers and occupancy. The number of hospital beds for people with mental health problems decreased by more than 60 per cent between 1987 and 2010 compared with a 32 per cent reduction in general and acute physical care beds (Department of Health form KH03 see Fig 1, opposite). However, new demands on beds have arisen from groups of service users who would not previously have been cared for in

**Figure 1** Average daily number of available beds, by sector, England, 1987/8 to 2009/10

Source: Department of Health form KH03

long-stay asylums. This was in part prompted by a policy of diverting people with mental health problems from the criminal justice system through initiatives such as court liaison and diversion schemes; and due also to an underestimation of the complexity of need of many people requiring care, particularly those who also misuse substances. Demand was further increased by providers closing beds in anticipation of the development and success of community services which were not always realised. As a consequence, there has been a rise in the use of private sector beds, particularly in the form of highly specialised and forensic units. In 2010/11 primary care trusts in England had invested £925 million in secure and psychiatric intensive care unit services, of which 34 per cent was with non-statutory providers (more than 50 per cent in some areas of the country) (NHS Confederation 2012). A particular challenge is the number of people placed out of their local area. A quality improvement analysis found that 23 per cent of spending on specialist mental health services in 2009/10 went on 'out-of-area' services – mainly placements in independent hospitals and care homes and various forms of housing with support (National Mental Health Development Unit 2011). The closure of inpatient beds remains one of the key methods of reducing costs and releasing capital for service development.

### The temptation to be overly optimistic

Some of those working in mental health services saw it as the role of the new services to provide service users with friends, income, networks, etc. For some of those who had been living in asylums for many years and were losing friendships of 50 years or more, that ambition was understandable, but with such an ambition the transformation was always going to under-deliver. In addition there were assumptions made about the extent of savings to be achieved by moving care into the community, and the ability to extract capital assets, which did not materialise.

### A lack of flexibility in implementation

The early phase of asylum closure was locally driven and innovative, with funding mechanisms that supported this. In many places, however, it took a long time to achieve

results and there was significant variation across the country. *Modernising mental health services* and the NSF for mental health saw a change of emphasis towards a more stringent national policy direction. The NSF for mental health articulated a set of key components, that had to be implemented and was supported by associated funding. Its focus on service structures, rather than the transformation process or desired outcomes for patients, resulted in an effective mechanism for implementation across the country, even in those localities where progress had previously been slow or non-existent. However, it also served to dampen much of the creativity and innovation in the system. Fidelity to the model became an end in itself without taking into account the context in which the models had been developed and the limited evidence base in the United Kingdom. This resulted in ‘ossified’ approaches to service development that were inappropriate to their local geography and requirements, and ultimately unsustainable. The timescale for implementation was also tight, which led in some instances to poor implementation.

### Conclusions: what lessons are there for the transformation of acute services?

Moving services from institutional to community or even home-based settings is also a long-standing policy goal for physical health services. While the NHS has seen major improvements in performance in the last decade, there are variations in quality and outcomes of care: the United Kingdom has the second highest rate of mortality amenable to health care in 16 high-income nations. Health and care services have struggled to keep pace with demographic pressures, the changing burden of disease, and rising patient and public expectations. Current spending projections suggest that health and social care services will face significant financial pressures in the next 20 years, with an estimated funding gap of more than £30 billion by 2021. These challenges will require the NHS to develop different models of care to ensure that patients receive high-quality, safe and effective care. The King’s Fund publication *Transforming the delivery of health and social care: the case for fundamental change* (Ham *et al* 2012) concluded that:

- the traditional dividing lines between GPs and hospital-based specialists, hospital and community-based services, and mental and physical health services mean that care is often fragmented, and integrated care is the exception rather than the rule
- current models of care appear to be outdated at a time when society and technologies are evolving rapidly and are changing the way patients interact with service providers
- care still relies too heavily on individual expertise and expensive professional input despite patients and users wanting to play a much more active role in their care and treatment.

These challenges will require physical health services to undergo a service transformation at least as significant as that which has occurred in mental health services over the past 50 years.

There is a danger of drawing overly simplistic parallels between the two types of transformation. It is important to note that the health system today is a different one from that which saw the beginnings of the significant changes in the mental health system. Notwithstanding these differences, there are some general lessons from the transformation of mental health services that could be applied to the current context.

### New models of care

The first lesson is that it is important to use the opportunity of changing the location of services to redesign the service model. Some of the residents of asylums, particularly older residents, were often simply rehoused in smaller institutions in the private sector. It might be argued that the acute sector already went through a similar transition

during the 1980s and 1990s when many NHS beds for older people were closed and the gaps filled by a major expansion in nursing and residential care in the private sector. The model of care did not change. Furthermore it is still the case that large numbers of frail older people remain in hospital. This suggests that a better starting point for comparison between mental health transformation and acute care is the period preceding the introduction of the NSF for mental health in 1999 rather than the original de-institutionalisation programme.

The lessons from mental health services suggest the need to develop new ways of working and to redesign services to incorporate a range of professions and roles. The development of multidisciplinary team working, with a mix of staff whose skills varied from being broad and generic to specialist areas, was critical to the success of community mental health services and will be equally important in physical health care. In mental health, consultants and other clinicians were encouraged to combine skills in order to work across traditional boundaries and sectors, providing care in multidisciplinary and cross-sector teams. Care co-ordination approaches were important in supporting integration of care and ensuring that the needs of individuals were adequately met. This model could be particularly useful for those with long-term conditions.

In terms of specific service models, developing services to cover each aspect of the care pathway was important in mental health services and will be equally critical in physical health care services. The pitfall of creating a complex range of poorly understood and poorly co-ordinated services should be avoided. Service systems need to allow for early intervention; treatment; and the ability to respond to crises and to facilitate the long-term management of people in community settings. These services need to be able to deal not just with those known to the system or a particular team, but also with crises in previously unknown or relapsing patients.

While the development of specialist teams for particular conditions has advantages, experience in mental health shows that it is important to ensure that these services do not become disconnected from other sectors including primary care and social care. The acute sector can learn from specialisation in mental health and the processes by which these links with other sectors are being re-established and developed.

Mental health has been willing to draw on emerging models to meet service delivery needs. Physical health care models from other countries, for example, the Kaiser approach from the United States and integrated care models from New Zealand, have had some traction in the United Kingdom. But they have not been integral to national policy in the way assertive outreach or crisis resolution approaches were, potentially because those models were mandated by national policy. However, as we have reflected, a national top-down approach to implementation did not have universally positive outcomes.

While adopting evidence-based care is important, recognising the limitations of particular approaches and adopting care appropriate to local needs is key. The NSF for mental health was important in clearly setting out both evidence and policy intentions and in achieving significant change. Although the prescriptive model set out in *The mental health policy implementation guide* (Department of Health 2001) ensured that new models of care were introduced, it did not account for differences in context between how the model was developed across local areas. Capacity to adequately develop services that reflect the needs of local populations is important.

Changing complex systems creates unexpected dynamics and changes elsewhere. In mental health the change in the model led to the identification of unmet and undiagnosed need. Societal perceptions of accessibility and needs have also created an environment of increased expectations and new demand. The models responded slowly to the development of increased demand or in adapting quickly enough to new demands – for example, the rise in demand for forensic services and dual diagnosis.

There are important lessons about the management of risk in community services. The public perceived the new mental health models as creating new risks for patients and others; some of these risks were not anticipated by policy-makers. The extent to which rare adverse incidents had a negative impact on the policy and its implementation was significant. While the risks in moving acute services into the community are different, the same problem arises – public opinion and policy-makers tend to overestimate the likelihood of low probability events with a large negative impact, particularly if one has happened recently (Lichtenstein *et al* 1978; Tversky and Kahneman 1973). The policy is vulnerable to a single adverse incident and planning for this requires more attention.

Finally, there is a very important lesson about the financial impact of moving to community-based models. Where these are replacing some inpatient services, it cannot be assumed that this is necessarily less expensive. The direct costs of inpatient care for patients receiving relatively little therapeutic input may be low whereas more appropriate community-based care and rehabilitation or re-ablement may be expensive – even though it may be more cost-effective in the long term. If there are savings these come from the reduction in overheads. In mental health there were opportunities for land sales and redevelopment; this may be less available on such a large scale in other parts of the health system.

## Change management

Large-scale change requires investment. The relocation of mental health patients was on a sufficient scale to allow the closure of whole institutions and the re-investment of their running costs into new services. There was also a major programme of building and property acquisition to support the new community services. In the acute sector, the number of beds that can be liberated through developing community services is significant but usually not on the same scale. This makes freeing up estate for sale more difficult and so other models of financial investment will need to be developed.

It is also important to note that organisations responsible for running down the large institutions were generally responsible for some or all of the alternative services that were being put in place. This meant that they were able to manage some of the financial and workforce consequences of the change more easily than is the case for acute trusts, where alternative services are often provided by other organisations. Whoever is responsible for managing the change, a clear lesson is that some double running of services is an important part of managing this type of change successfully.

Developing financial frameworks to support and sustain transformation is important, particularly if there is double running of services. The large-scale de-institutionalisation process was underpinned by investment in double-running costs, the development of a long-term financial framework tied to land sales, dowry payments and new models of financing, such as the joint finance initiative. These enabled money to be moved in a protected way that ensured new models could be up and running before the institutions themselves were closed. This commitment that savings would be re-invested was crucial for overcoming professional resistance to change. Lessons from more recent local innovation highlight the importance of considering funding arrangements that not only account for the initial development but support long-term sustainability.

This last point illustrates one important difference between the change process in mental health over the past 50 years and proposals for change in the acute sector now – the importance of a planning and strategic leadership function. The regional health authorities did not always deliver and sometimes redirected money for mental health strategic change into operational spending. But their ability to oversee the process, bring the different parties together and broker the financial deals was very important. Planning, commissioning and provision of health services today is performed by significantly more

organisations than was the case in the 1980s and it is no longer very clear who should or would take the role of system leader in making this type of change.

In mental health the move to close the big institutions was driven by a social movement with a strong narrative about why change was required. The arguments were powerful and evidence-based and seemed to have enjoyed more widespread support among clinicians than is sometimes the case in the proposed changes in the acute sector. The lesson that the enthusiasts can bulldoze colleagues with counter-productive effects still needs to be learnt. Patient and carer-led activism has also been an important part of building the case for change. In acute care the exponents of change have arguments of varying degrees of validity, but there is not the same moral force as was found in mental health services – with the exception of arguments for reducing the use of hospital at the end of life.

While there have been scandals in acute hospital care, these are interpreted as a signal that hospital care needs to be improved for those who require it, rather than as a prompt for the wholesale movement of care out of hospitals. If there are social movements in the acute sector it is more likely that they are directed at keeping institutions open rather than closing them. The attitude of politicians tends to follow this. By contrast, there was little opposition and often support for changes in the large mental health institutions, albeit with some active opposition to the development of local mental health services. Political leadership was important at stages of the transformation of mental health services, and politicians were important in moving mental health up the agenda, particularly in the early 1960s and in the early 2000s, although the political emphasis on mental health was by no means constant.

Finally, large-scale change and the employment of new approaches require support for improvement, service design, staff training and new ways of working. This needs to be supported with improvement methodologies at a national level, such as existed for mental health services. Different incarnations of agencies and bodies that could assist the acute sector have often come and gone, victims of re-organisations and inter-organisational rivalry. This remains a significant gap and although the Berwick report called for organisations to be part of improvement collaboratives, this cross-organisational approach to learning and change is largely absent ([National Advisory Group on the Safety of Patients in England 2013](#)).

## Conclusions

It is possible to push the analogy between mental health and physical health services too far. The diversity of patients in the acute sector is much greater, the range of conditions much wider and the number of services and staff that need to be re-shaped more numerous than in mental health services. There is less ability to focus on change, no big breakthrough in treatment analogous to the introduction of antipsychotics and, while there are new service models that allow a significant shift in how and where care happens, these tend to be for particular conditions or sub-groups.

The overall lesson is that history may look neat and linear in retrospect but at the time it is messy and has false starts, dead ends and reversals that tend to be smoothed out when looking back. The story of change in mental health follows this pattern and although it is difficult to predict the emerging needs and changes in society that drive a certain proportion of change, there is an argument that those leading change need to think long term. The process of transformation is one of continual evolution; in mental health it has taken more than 50 years so far, and there is still more to do.

Despite these differences, our analysis shows that there are important lessons from the transformation of mental health services that indicate the scale of the challenges involved in changing acute services and offer pointers on how these might be addressed. Change is hard, requires investment in advance of any savings and will require experiment and

evaluation, but it will transform the lives of people using services. We hope that health and social care leaders will find it useful to reflect on these lessons in planning how acute services can be made fit for the future.

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**Edward Peck** is a Professor of Public Services Development and is currently Pro-Vice Chancellor and Head of the College of Social Sciences at the University of Birmingham; from 1 August 2014 he will be Vice Chancellor of Nottingham Trent University. Prior to joining the University of Birmingham as Director of the Health Services Management Centre, he was Director of the Centre for Mental Health Services Development at King's College London, which played a central role in the transformation of mental health services in the United Kingdom.

**Becky Ashton** has worked at The King's Fund since 2007, first as Adviser to the Chief Executive and now as Policy Manager co-ordinating the Fund's work on the reform and performance of the health and social care system.

She has a background in the NHS and social care, and before joining the Fund was Associate Director for Service Improvement at South East London Cancer Network. Prior to this she spent two years in San Mateo County, California, developing a model of integrated health and social care funding and delivery for older people. She began her career as a researcher and undertook a variety of roles in older people and mental health services, including a short secondment to the Department of Health to work on the development of the National Service Framework for Older People. She has an MSc in Health Systems Management from the London School of Hygiene and Tropical Medicine.

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Chris previously worked in research teams at the Sainsbury Centre for Mental Health and the Institute of Psychiatry, and has an MSc in public health from the London School of Hygiene and Tropical Medicine. Chris is currently on sabbatical.

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