

REPORT

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Developing social care: the current position



Chapter 5: People with mental health problems

Distinguishing social care

There is good news and bad news. The good news is that partnership working between health and social care has moved a long way forward. The bad news is that integration, at least structurally if not culturally, makes it enormously difficult for a review such as this to separate social care from other inputs to mental health services. As Robbins (2004) for the SSI writes:

It is increasingly difficult, and inappropriate to distinguish precisely between the contributions of the different agencies ... in promoting and supporting mental well being' (p.1).

More and more, social work and social care staff are working in teams integrated with NHS staff, in hospitals, primary care settings, outreach teams, clinics, day centres, multi-purpose units and 'one stop shops' offering health, social services and perhaps housing and benefits advice' (p.4).

There are a lot of reasons for seeing this as a positive step forward. Three of the four initial 'demonstration' Care Trusts focused on services for people with mental health problems. Last year's summary of clinical governance reviews of mental health trusts by CHI makes plain that partnership working has clearly moved some distance in the mental health field, particularly compared to the situation in the 1980s and early 1990s. And the NIMHE (2002g) booklet on partnership working identifies numerous important advances. Nevertheless, to quote Robbins (2004) again, 'Responsibility for delivery, quality and consistency of social care remains clearly with councils with social services responsibilities' (p.1).

The NIMHE website (accessed July 2004) explains the roles of social care in the mental health field:

Social care services strive to empower people to deal with these difficulties [unemployment, homelessness or isolation, crisis in relationships with carers or family] and to provide support where it is needed. They are delivered by local councils, voluntary and independent organisations. Increasingly, social care is characterised by partnerships between social services and many agencies across government and the voluntary sector, but also there is a strong trend towards closer integration of health and social care services. Amidst all this complexity and change it is critical that mental health remains firmly on the agenda of the social care sector.

This explanation emphasises three important features of social care in the mental health domain today. First, social care services are aiming to support people in a number of need domains, including those relating to work, accommodation and personal relationships. Second, the partnership between social services and other agencies, especially the NHS, is fundamental to the organisation of mental health care in the UK today. However, and third, although it is difficult to distinguish the separate contributions of social care, the importance of retaining a distinctive social care contribution is paramount.

One consequence is that we stray much farther into health care territory in this chapter than in others. We can identify levels of social care expenditure and some specific social care services, but we will also need to review the development and impacts of multi-disciplinary community mental health teams (CMHTs), assertive outreach services and psychiatric hospital provision. Our review will also need to cover the health service's care programme approach (the *original* CPA, of course!) because it is intertwined in such complex ways with (social services) care management. We shall even have to use both the *case* and *care* management terms if we are to engage with the more clinical evidence base.

The changes that have occurred in the mental health field over 15 years have been considerable and there is just cause for both celebration and concern. But generally, should anyone wish to do so, they would struggle to allocate plaudits or to apportion blame between health, social care or other services.

A final prefatory remark is to point to the ten brief, useful booklets published under the *Cases for Change* series by NIMHE (2003a to 2003j). These short, accessible publications review the mental health evidence up to late 2002, ranging wider than we can (or need to) in this chapter, but not as deeply. The ten booklets are organised by topic (such as primary care, community care, hospital services, forensic mental health services, and user involvement), but, interestingly, there is no booklet on social care. The publication that deals with partnership working across health and social care is informative in tackling the key issues, but does not specifically identify social care activities. Nor could we find them separately discussed elsewhere in the series.

Policy context

Pre-1990 challenges

Various problems could be said to have characterised the pre-1990 mental health care system, including information deficiencies, boundary problems, perverse incentives and inequitable allocations. Information systems may have been just about sufficient for the purposes of financial control and (old style) public accountability, but were certainly not capable of monitoring service quality, checking user outcomes, highlighting inequalities or analysing inefficiencies. Boundaries between agencies were sources of confusion, friction and frustration; and they tended to shift with successive organisational changes. Because many mental health service users have multiple needs that require them to (try to) access services from a range of agencies, boundaries are very important to them. Blurred, dislocated or shifting boundaries can so easily lead to segregation rather than integration, treatment failure rather than treatment success (NIMHE 2003g). Perverse incentives often followed in the pre-1990 context: agencies or professionals were pressured into looking first to their own interests and only later to consider the wider picture. Resources and benefits were not equitably allocated, despite nationally coordinated, universal health and social care systems. 'The *Better Services for the Mentally Ill* set out in a Government White Paper in 1975 had ... failed to materialise in most places' (Department of Health 2001g p.4). Service users involvement in decision-making was limited.

These long-standing difficulties were held to have led in turn to poor targeting, service fragmentation and cost shifting. In other words, the pre-1990 mental health system was widely seen to be both inefficient and inequitable (Kavanagh and Knapp 1995).

The 1990 NHS and Community Care Act

The 1990 Act, the Griffiths report and White Paper that preceded it and its sequelae gave emphasis to a number of changes, with at least the following of particular relevance to mental health.

- The intention was to move away from decision-making dominated by the availability of services to a system that tailored service responses to the needs and preferences of individual users and their families. Examples of developments since 1990 include emphasis on care management, introduction of the care programme approach (although seen by some as more reactive to a perceived short-term crisis, as we

discuss below), promotion of supervision registers and greater attention to (increasingly multi-disciplinary) assessments.

- Second, encouragement was given to the continued growth of the mixed economy of provision. The health and social care systems were to be less dominated by services delivered in-house by the NHS and local authorities. In fact, this mixed economy was already far better established in the mental health sector than in almost every other diagnostic or health service field. What we have seen subsequently has been continued expansion of private and voluntary sector provision, as in other social care areas.
- A key instrument for the development of the mixed economy of provision was the internal market (or quasi-market, to be more precise). The basic premise was to move away from an administrative hierarchy to a market (or market-like) regime, with commissioning rather than management as the primary means by which service delivery would be controlled. The initial moves down this track were quite modest until the establishment of PCGs and PCTs.
- Service users and their families were to be given bigger roles in decision-making in relation to their care and treatment, although again progress was slow.
- Across the full spectrum of needs there was to be some rebalancing of the responsibilities of the NHS and local authorities. Two very noticeable consequences over the past decade and more have been growth in local authority spending on mental health (assisted initially by the introduction of the Mental Illness Specific Grant to channel money to social services departments, although in volume terms this was small, and later boosted by transferred responsibilities from the DSS) and closer integration of health and social care activities (exemplified by the widespread establishment of multi-disciplinary community mental health teams, assertive outreach services and so on).
- Another major element of the 1990 legislation was obviously reaffirmation of the aim to substitute community-based for institutional provision, which in the mental health sector meant closing more of the old asylums, transferring some inpatient provision to general hospitals and encouraging the opening of a range of new community facilities. Hospital bed numbers had been falling steadily since the mid 1950s, and encouraging evidence from the Care in the Community demonstration programme (later published in Knapp et al 1992) and other smaller studies in the 1980s fed this aim.

Early reflections

Early reflections on the 1990 legislation as it played out in the mental health area were decidedly mixed. There was a lot of support for the community-focused emphasis, for needs-based planning, for (some) clarification of the respective roles of health and social care agencies, and for the injection of (albeit modest) ring-fenced funds for local authority mental health services. It was also recognised that no single piece of legislation, however imaginatively conceived or carefully crafted, could be expected to solve all of the problems of the 1980s. For example, information about population needs was improving, but routine outcome data would inevitably take some years to generate (and we are not there yet, of course, although the mental health minimum data set is moving us in the right direction). Boundaries between agencies shifted but underlying difficulties remained because of different priorities and cultures (Bean and Mounser 1973). New pressures to demonstrate performance, highly laudable in their own right, introduced a new set of perverse incentives.

Inequities continued to be of concern, with evidence confirming, among other things, the persistence of major disadvantage in London and other major cities (Johnson et al 1997), marked variations in prevalence rates by socio-economic group (Melzer et al 2003), and broader problems of the social exclusion of people with mental health problems (ODPM 2004). The recent finding of the inquiry into the death of David Bennett that mental health services are 'institutionally racist' hardly describes a satisfactory situation. Finally, the over-rapid closure of some inpatient facilities without adequate replacement with community accommodation was a concern to many. It led – it was argued – to 'revolving door' patterns of service use, homelessness, increases in custodial detention of people with mental health problems and generally impoverished quality of life. Even so, the incoming Labour Secretary of State for Health's assertion that 'community care has failed' drew much criticism, not least for its stigmatising tone (Clements 1998).

Funding arrangements

New problems were also emerging as a result of some of the organisational changes introduced by the 1990 Act (Kavanagh and Knapp 1995; Shepherd et al 1996). From across the Atlantic, Hadley and Goldman (1995) offered scathing comments on the 1990 Act. They were highly critical of some of the changes, particularly the untidy, fragmented, almost certainly inefficient new funding arrangements. At that time there were purchasing or funding responsibilities for the new GP fund holders (GPFHs), for the continuing health authorities and of course for local authority social services departments. Because of limitations on the costs that would fall to GPFHs and other

transitional issues, some perverse incentives were created, particularly for primary care and social services purchasers to make more use of inpatient services.

One of the arrangements introduced by the 1990 Act was to pass devolved budgets to primary care practices (initially only those with more than 11,000 people on their lists, but later reduced to 5,000). Fundholders had the freedom to purchase secondary care services from anywhere in the public system (or indeed outside it), although inpatient psychiatric care, hostel placements, forensic psychiatry and some other services were excluded from standard fundholding. A few 'total purchasing' pilots and multi-funds gave GPFHs powers to purchase these other services. GPFHs were arguably more cost-conscious and patient-responsive. They used 'implicit preferred providers and implicit rationing mechanisms to reduce costs' (Fairfield et al 1997), and have increased the availability of counselling services in primary care (with as yet unclear consequences; Shepherd et al 1997; Churchill et al 2001). Concerns were expressed about sub-therapeutic prescribing for depression (Donoghue and Tylee 1996), poor schizophrenia care (Audit Commission 1996; Kavanagh 1997), inadequate targeting on serious mental illness (Lelliott and Audini 1996) and tensions between primary and secondary services (Gask et al 1998). In fact, the ability of primary care doctors to identify mental health problems is a long-standing and unresolved issue (Sainsbury Centre for Mental Health 2002; NIMHE 2003c). However, it may well be that secondary mental health services are now being targeted better on more needy patients, and that the growing practice of providing special mental health services in primary care settings can divert more people away from secondary care (Kendrick et al 2004).

The introduction of the NHS internal market made it necessary to be much more explicit about costs, expected effects of interventions and criteria to be employed in rationing. However, commissioning of *mental health services* was often of poor quality, lacked strategic intent and insight, was poorly coordinated with GP fundholders, relied on limited and often uninformative data, and embodied continuing perverse incentives (Simpson, 1998; Cumella et al 1996). Although most attention post-1990 was thus focused on changes to the routing of health care funding, the introduction of GPFHs (and later PCGs and PCTs) had relevance for the roles of social care funding and services in the mental health arena.

Care programmes and care management

In their review from a US perspective of the UK reforms, Hadley and Goldman (1995) were critical of a number of developments, and particularly the parallel systems of care management in social services and care programming in the NHS (the CPA). The two had more or less the same objectives but quite different locations and purchasing platforms. 'They have also accentuated the differences between health and social

services teams and have probably made joint working more, rather than less, difficult' (p.1556).

As in the United States, the mental health system in Britain is now characterised by a multiplicity of payers, which leads to poor continuity of care and major inefficiencies in resource allocation. In general, these conflicts mean that collaboration across sectors must take place despite financial incentives rather than being supported by them. It is not a hopeful model for joint planning or for developing coherent policy (p.1557).

Risk minimisation

The CPA was closely associated in many people's minds with risk management. A recent useful review of the development of the approach and its links with case or care management is highly critical:

Had the CPA embraced the positive principles of the strengths model, it might have provided mental health services with the unifying philosophy that has been found lacking and that continues to undermine collaborative team working which is essential in effective case management. ... But such an approach would have been at odds, not only with the dominant medical model of mental illness but also the political hegemony of that time. The primary drivers behind the introduction of the CPA were the targeting of restrictive resources and the quelling of exaggerated fears of 'homicidal maniacs', not the empowerment and fulfilment of people with mental illness (Simpson et al 2003, p.480).

Some mental illnesses can of course have societal consequences, such as the impact on crime and perceptions of personal safety. But the probability of such an event is frequently exaggerated. In a very careful analysis, Taylor and Gunn (1999) suggested that 'about 10 per cent of those convicted of homicide in England and Wales suffer from schizophrenia' (p.10). More recently, Shaw et al (2004) looked at the frequency of homicides committed by strangers and the links to mental illness, concluding that 'the increase in stranger homicides is not the result of homicides by people with mental illness and therefore the policy of care in the community' (p.736).

This is not to deny that better mental health services cannot contribute to risk reduction, for example by helping service users to maintain contact with treatment and to take their medications. However, mental health policy in the period leading up to and following the 1990 Act was increasingly concerned with personal and (especially) public safety. Holloway (1996) described the 'moral panic' over community care since the early 1990s,

leading to policies and practices dominated by minimisation of the risk of violence to themselves or others by people with mental health problems. One consequence has been the growth of coercion, close monitoring and a rapid increase in compulsory inpatient admissions (see also Goodwin 1997). The growth in the number of secure units has been labelled a return to 'asylumdom' (Morrall and Hazelton 2000). (See also Patterson et al (2003) on deaths associated with the use of restraint in health and social care settings.)

Not long after the 1990 legislation took effect, two developments were added to the CPA to try to 'balance the issues of risk and vulnerability in the community' (NIMHE 2003b p.3). Locally maintained supervision registers were set up in 1994 as

part of the policy response to concern about perceived high profile failures of psychiatric care. The supervision registers were intended to identify all patients under the care of specialist psychiatric services who are, or are liable to be, at risk of committing serious violence or suicide, or of serious self-neglect (Bindman et al 2000 p.33).

The view from the Socialist Review was that, in response to growing concerns about an underdeveloped community care system:

[Secretary of State] Bottomley's only answer has been to turn to more repressive measures. Following the case of Ben Silcock – the young schizophrenic man who was mauled by a lion at the zoo last year - Bottomley's knee jerk response was to push for the introduction of compulsory treatment orders. Even the House of Commons health committee found the idea 'fundamentally flawed' and liable to contravene the European Convention on Human Rights. This April [1994] Bottomley plans to introduce registers of the most severely mentally ill (Croft 1994).

The supervision register was inconsistently and ineffectively implemented (Bindman et al 2000) and was transformed into today's two-tier CPA. We return to the CPA later in the chapter.

Supervised discharge orders (SDOs) were introduced as an amendment to the Mental Health Act in England and Wales in 1995, setting specific conditions for patients who were being discharged from hospital. The initial reaction (at least) to SDOs from mental health professionals was sceptical. Pinfold et al (2001) examined the use of SDOs in England and their ability to improve adherence with medication regimes, based upon an interview study with mental health trusts and local authorities. They note the limited number of patients covered by SDOs and the great variation in implementation.

Wolff (2002) provides an interesting analysis and reflection on how mental health policy in England 'has historically mismanaged the risk issue... and as such has set in motion the growing community care backlash' (p.801). In a critical appraisal of policy, not just in the period following the 1990 Act but under the present government, she argues that

Mental health policy fails because it is designed to minimise the wrong risks – the risks of violence among a small number of persons with mental illness and the political liabilities and responsibilities of the political official. Policies that promote and perpetuate risk aversion, as reflected in Labour's modernising policy, promote the following ends: short-run chaos, ... more security-focused treatment regimes, ... a more expensive system of care, ... implementation uncertainty, ... public disillusionment.

She discusses solutions such as a more truthful presentation of the issues, a more appropriate focus for policy, top-level accountability for policy dissemination, denunciation of the blame culture and development of better strategic leadership. Many users see a worrying trend in the emphasis on control over care. They 'feel that the focus by the government and the media on risk and dangerousness add to the stigma and prejudice they experience' (Levenson et al 2003 p.3).

The 1997 white paper

The incoming Labour government's policy intentions for the NHS (across the full range of health care needs and responsibilities) were set out in the 1997 White Paper, *The New NHS*. Underlying the proposed changes were six basic principles (quoted from paragraph 2.4):

- to achieve a genuinely national service with fair access to consistently high quality, prompt and accessible services;
- to clarify local responsibilities for achieving the new national standards;
- to get the NHS to work in partnership, especially with local authorities (the public agency responsible for social services);
- to drive efficiency by improving performance and cutting bureaucracy;
- to guarantee excellence by ensuring that quality is the driving force for decision-making; and

- to rebuild public confidence in the NHS as a public service, accountable and responsive to the public.

The third principle ('joined-up government') was intended to tackle the long-standing problems of boundary disputes and perverse incentives. The fourth (efficiency promotion) had wide relevance, of course, but was particularly pertinent in addressing the tendency for cost shifting between different public and other agencies. The sixth may have been inspired by political positioning, but could obviously be linked in the mental health field to the challenge of countering the (growing and often inflammatory) media (and ministerial) criticism of Britain's 'failing' mental health care services that followed high-profile incidents of violence involving people with mental health problems (in turn undermining public confidence in community-based care). A 'safety-first', risk-minimisation approach to mental health care continues to be very influential today, as exemplified by proposals to reform legislation allowing compulsory treatment, and by growth in the numbers of secure beds. (According to a Department of Health memorandum to the House of Commons Health Committee, there were 1493 medium secure beds in England in 1997/98 and 2231 in 2000/01.) NIMHE (2003b) calls this and other related action the 'balancing of risk and vulnerability in the community', while others use more critical language. 'A disproportionate emphasis on dangerousness and risk has meant that much of the early investment of modernisation monies has been concentrated on secure services. This has inevitably deflected attention from the continuing development of the very services that can help people stay out of hospital' (Levenson et al 2003 pp.1-2).

The 1997 White Paper set six broad criteria for successful health care (see also Secretary of State for Health 1998):

- *health improvement*, relating to the overall health of populations, and recognising the important roles played by social and environmental factors;
- *fair access*, in relation to need, irrespective of locality, socio-economic status, demographic characteristics or care group (such as learning disability);
- *effective delivery of appropriate health care*, that is services which are clinically effective, appropriate to need, timely, conforming to agreed standards and delivered by appropriately trained staff;
- *efficiency*, balancing the outcomes with the resources that need to be employed;
- *patient/caregiver experiences* should be positive, for example services should be perceived to be responsive to needs and preferences, there should be continuity of care, and information and choice should be offered; and

- *health outcomes of NHS care* should, for example, reduce levels of disease, impairment and complications of treatment, and should improve patient and caregiver quality of life.

Each aim clearly applied to mental health care as much as any other area of the NHS. The first aim was preventive, to reduce the need for any formal involvement by the health service. When health care is needed, the next aims were then to target it on the right people, at the most appropriate cost (efficiency), as sensitively and conveniently as possible for users and caregivers, in order to achieve good clinical and quality of life outcomes, and then feeding back to the first aim of health improvement.

The White Paper also announced the end of the internal market, to be replaced by ... well, something that looked remarkably like another internal market, although not to be described as such.

The strategy to improve both quality and efficiency had a number of prongs, each with relevance for our evidence review. The first was to set service standards, principally via the NSF (and mental health got high priority here, with its Framework published in 1999 – see below) and the assessments by NICE. The second was to ensure dependable local delivery. This would be achieved mainly through professional self-regulation, lifelong learning by staff and clinical governance, defined as ‘a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish’ (Secretary of State for Health 1998 p.33), in turn linked to clinical audit and evidence-based practice (building on guidance from NICE and the NSF) and the pursuit of ‘best value’ by local authorities.

The third strategic aim was to draw up health improvement programmes guided nationally by NICE and the NSF, but obviously dependent on local implementation. PCG/Ts would have key roles to play, working closely with social services. One particular concern expressed in the 1990s grew out of the experiences of the ‘total purchasing’ pilots (looking at those GPFHs who assumed much wider purchasing powers): the worst level of self-rated achievement was in relation to mental health (Goodwin et al 1998). Finally, there was a need for monitoring standards to ensure that standards set nationally were achieved locally. The Commission for Health Improvement played the key role in this monitoring, developing clinical governance principles, independently scrutinising local arrangements through its rolling review programme, and helping to identify and tackle ‘serious or persistent clinical problems’. The whole could be seen as broadening the terms of, and deepening the commitment to accountability.

Modernising mental health services

The mental health mantra of the incoming Labour government mental health policy was that services should be safe, sound and supportive. The 1998 White Paper, *Modernising Mental Health Services* (with the three Ss added in the subtitle), set out a new mental health strategy that promised 'Extra investment and new systems to manage resources more effectively, well-integrated care processes, crossing professional and agency boundaries, legal powers which work with and underpin comprehensive local services' (Department of Health 1998c p.8). *Modernising Mental Health Services* set out the advantages of specialist mental health NHS Trusts. Among the specific requirements were high quality senior leadership, clinical governance, commitment to education and training, recruitment and retention, information services and research and development, and clear lines of accountability.

Specific arrangements would need to be in place for service user and carer involvement. Advocacy, integration of care management and the CPA, and effective partnerships between acute trusts, primary health care, social services, housing and other agencies were all argued to be more likely if specialist mental health trusts were established, certainly in major urban areas. Service accommodation and 24-hour staffed facilities would be expanded, and there was specific mention for the first time in policy documents of assertive outreach and crisis resolution teams. There was said to be a need for:

a system which provides both security and support to all who need it. This cannot be achieved by going back to locking up mentally ill patients in long-stay institutions so they are out of sight and out of mind. That was harsh and harmful. But the present system which can leave people with problems off the books is letting down both patients and the public (Department of Health 1998c).

In the same year, a health service circular focused on commissioning of more specialised services (medium and high secure psychiatric services, services for eating disorders, etc). The incoming government also announced a thorough review of the Mental Health Act covering compulsory treatment (Department of Health 2000). The debate around 'care or control' has raged ever since (for a brief discussion see NIMHE 2003b, 2003f and the references therein). We do not delve much further into this area in this chapter.

National Service Framework

Hard on the heels of the 1998 mental health white paper came a number of linked initiatives and announcements. Specific service proposals for mental health followed with publication of the National Service Framework in 1999. The NSF was evidence-based, set national standards, defined service models and suggested measures of performance and milestones to gauge progress over a ten-year programme. It was generally enthusiastically accepted. The external reference group of the NSF developed a number of 'guiding values and principles' to help shape decisions on service delivery. Repeating the guiding principles set out in *Modernising Mental Health Services*, the NSF argued that people with mental health problems should be able to expect that services will:

- 'involve service users and their carers in planning and delivery of care
- deliver high quality treatment and care which is known to be effective and acceptable
- be well suited to those who use them and non-discriminatory
- be accessible so that help can be obtained when and where it is needed
- promote their safety and that of their carers, staff and the wider public
- offer choices which promote independence
- be well co-ordinated between all staff and agencies
- deliver continuity of care for as long as this is needed
- empower and support their staff
- be properly accountable to the public, service users and carers' (Department of Health 1999 p.4).

In many respects the NSF therefore reaffirmed long-standing and widely accepted principles. It was considered too 'bland' by the Royal College of Psychiatrists (Deahl et al 2000), and was also seen by some commentators as further reinforcing the risk management agenda (eg Sainsbury Centre for Mental Health 1999). However, the NSF encouraged a clearer focus and channelled energy and commitment.

Seven standards spanned the areas of mental health promotion, primary care and access to services, effective services for people with severe mental illness, caring about carers, preventing suicide.

1. Health and social services should promote mental health for all, working with individuals and communities; combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.
2. Any service user who contacts their primary health care team with a common mental health problem should have their mental health needs identified and assessed, and be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.
3. Any individual with a common mental health problem should be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care; and be able to use NHS Direct, as it develops, for first-level advice and referral on to specialist help lines or to local services.
4. All mental health service users on CPA should receive care which optimises engagement, anticipates or prevents a crisis, and reduces risk; and have a copy of a written care plan.
5. Each service user who is assessed as requiring a period of care away from their home should have timely access to an appropriate hospital bed or alternative bed or place which is in the least restrictive environment consistent with the need to protect them and the public, and as close to home as possible; and a copy of a written after-care plan agreed on discharge.
6. All individuals who provide regular and substantial care for a person on CPA should have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis; and have their own written care plan.
7. Local health and social care communities should prevent suicide (and the standard then goes on to list the ways in which this should be done).

Local implementation teams (LITs) were to be established to be responsible for implementing the NSF. The NSF was followed by a number of implementation activities, including some set by the milestones and performance indicators. The NHS Mental Health Modernisation Fund provided an additional £40 million in the first year, and other funds were made available subsequently.

Plans, PIGs and performance

Consistent with the new standards, the *NHS Plan 2000* announced intentions for the next ten years. These included expansions to the numbers of specialist teams, including early intervention, assertive outreach and crisis resolution teams. A number of other pledges were made, including expansion of the workforce in both primary and secondary care, development of new accommodation and better services for prisoners and people leaving prison with mental health problems. (Some years ago Robertson et al 1994 discussed the 'cumbersome and extremely inefficient' treatment of the mental health needs of remanded prisoners. Progress has been very slow.)

Specific commitments with respect to mental health service developments were elaborated in a Policy Implementation Guide (PIG) (Department of Health 2001f), now with obligatory (but welcome – provided it is grounded) commitment to 'whole system' approaches. Among other things, the PIG detailed the previously announced 'functionally differentiated service model' of three specialist teams to replace or complement the generic CMHT model that had dominated for some years. These teams included a crisis resolution and home treatment team to decrease admissions to inpatient care, an early intervention psychosis service to manage new cases of psychosis in young adults and teenagers, and an assertive outreach team to co-ordinate and manage treatment and support for service users who are otherwise difficult to engage with services. The PIG has subsequently been developed with guidance on the management of dual diagnosis, intensive care and secure services (details available on the DH website).

The Social Perspectives for Network for Modern Mental Health was launched with DH funding in 2002 to encourage all service users, carers and relevant workers to support a modern, user-centred approach to mental health (as described by Robbins 2004). The National Institute for Mental Health in England (NIMHE) was launched in 2002 with the task of 'supporting local communities to improve mental health and the quality of services for people affected by mental health problems' (NIMHE website).

The NHS performance assessment framework (PAF) was published in April 1999. It spanned six domains: improving people's health, fair access to services, delivering effective health care, efficiency, the experience of patients and their carers, health outcomes. The social care PAF was organised around the five Best Value performance domains: national priorities and strategic objectives, cost and efficiency, effectiveness of service delivery and outcomes, quality of services for service users and carers, fair access. Subsequently a number of changes have been made to the frameworks within which these performance indicators will be interpreted, and more generally the ways in which services and authorities are audited and inspected. The only mental health

performance indicator relating to user outcomes is the suicide rate. All other indicators relate to funding, inputs, process and services.

Current policy emphases

Today's mental health policies are intended to 'overcome a legacy of neglect' (Department of Health 2001g p.3). Central to this intention are a number of roles for social care:

Modern mental health services are designed to break the cycle of social exclusion, promote recovery and provide a model of care which supports service users as far as possible in the community, while providing effective treatment in hospital when necessary. This model depends on the kinds of support which only integrated services set up by inter-agency partnerships can provide (Nottage and Appleby, foreword to Robbins 2004).

The key elements of mental health policy today can be picked out of this quote: tackling social exclusion, promoting better health ('recovery'), supporting people with mental health problems in the community where possible, and using hospital admissions where necessary (and not seeing them as an indication of failure) in an integrated context.

Government mental health policy is focused on how to ensure that all those with mental ill health are able to access timely and effective, evidence-based services and receive any treatment and care they need. New investment has been directed towards the provision of new teams, staff and services... new money, clear targets and new structures and institutions have been put in place to ensure that all this happens (Robbins 2004 p.1).

In June 2004, a helpfully detailed report from the ODPM (2004) set out an action plan for addressing the social exclusion of people with mental health problems, including tackling stigma and discrimination, implementing evidence-based practice in vocational services to support community reintegration, giving people with mental health problems a real chance of sustained paid employment, supporting families and community participation (in ways that people choose), giving access to decent homes, financial advice and transport; acknowledging social networks and family relationships, and generally building confidence and trust (see pp.6, 22-23).

This welcome focus on the social exclusion of people with mental health problems builds on positive attempts to outlaw discrimination against people with disabilities (especially the *Disability Discrimination Act 1995* and the *Welfare to Work* programme;

see NIMHE 2003h). We will return to the social inclusion theme at various points in this chapter.

Policy priorities and intentions in Wales and Northern Ireland are similar to those in England. The All Wales Mental Health Strategy was first published in 1989, and most recently revised in September 2001. The underlying principles of equity, empowerment, effectiveness and efficiency lead to eleven aims (quoting from National Assembly for Wales 2001):

8. To educate the public about the effective treatments of mental illness in order to develop positive attitudes and reduce stigma. To incorporate mental health into the wider health, well being and social agenda, to ensure good mental health promotion is at the heart of our approach to services.
9. To provide equitable access to mental health services for all people of Wales, irrespective of where they live, their age, gender, sexuality, disability, race, ethnicity or their social, cultural and religious background.
10. To include users and carers in the planning, commissioning and delivery of services, and take account of individual preferences and lifestyles.
11. To ensure close co-operation between social services, health authorities and the voluntary and private sectors in order to commission effective, comprehensive and co-ordinated mental health services.
12. To provide support which will enhance the ability to cope, with the individual remaining in control of their lives and to facilitate integration and mental health service users in all aspects of community life.
13. To assess the medical, psychological and social needs of service users and carers at an appropriate time and with reviews at regular intervals.
14. To provide effective and high quality care based on the best evidence and including provision for the medical, psychological and social needs of service users and carers.
15. To provide mental health services in settings that are fit for purpose, providing dignity and privacy.
16. To protect users, carers and the public from avoidable harm while respecting the rights of users and their carers.

17. To ensure good communication and co-ordination between different parts of the mental health service in order to provide efficient, responsive and seamless care.
18. To recruit and retain highly trained staff of all disciplines who are confident of their skills and have high morale.

In Northern Ireland, the Department of Health, Social Services and Public Safety (2003) Strategy and Action Plan for Mental Health has four aims: 'improve people's mental and emotional well being, in particular that of people at risk or vulnerable, and people with identified mental health problems, their carers and families; prevent, or reduce the incidence of, mental and emotional distress, anxiety, mental illness and suicide; raise awareness of the determinants of mental and emotional health at public, professional, and policy making levels and reduce discrimination against people with mental health problems; ensure that all those with a contribution to make are knowledgeable, skilled and aware of effective practice in mental and emotional health promotion' (p.8). Three underpinning principles are set out: a holistic approach to mental health, empowerment of individuals by enhancing their knowledge and skills, and respect for personal dignity ('recognising that all people have dignity, and deserve social justice, fairness, respect and equality of opportunity' p.9). Part of the strategy is an emphasis on 'effective mental and emotional health promotion'.

In reviewing needs, resources, services and outcomes in the remainder of this chapter it is helpful to bear in mind the main dimensions of change since the later 1980s: the continued move away from hospital towards community-based services; the increasing integration of social care with health care; the growing reliance on primary care; the broadening of the concept of need with the increasing emphasis on promoting mental well being rather than just treating mental illness; the greater emphasis on social inclusion; the growth of user involvement; and a number of reconfigurations of community-based teams.

Needs

Roughly 1 in 200 adults have a severe and enduring psychiatric disorder each year, and about 1 in 25 adults have a personality disorder (Singleton et al 2001). In addition, an estimated one person in six has a common mental health problem at any one time. There is a great deal of evidence from the epidemiology and mental health services literatures on the prevalence of mental health problems and the nature of need, but we are not especially concerned with the detail of these findings here. Our interest is need as seen through the kind of lens usually worn by the social care system.

What we must note from that wider literature, however, is that many people who have mental health problems do not access services. This might be because of ignorance as to their health needs, or because they feel shame or embarrassment, or because they cannot find or get to see the appropriate professionals or services. The 1993/94 and 2000 Psychiatric Morbidity Surveys reveal considerable volumes of unrecognised, untreated and under-treated mental health need. Second, many people with mental health problems, especially those problems that are more severe or enduring, have multiple needs spanning the responsibilities of two, three or more different agencies. They may need support not just from the health service but from local authority social services and housing departments. They may need income supplementation and help finding paid employment, and some may have regular contacts with the criminal justice system. Their needs are therefore multidimensional. Even within the health domain, substance misuse problems are a quite common comorbidity (Farrell et al 1998; Graham et al 2001), as are other 'physical health' comorbidities.

Prevalence and preference

Need and prevalence are linked to deprivation (a core social care concern, of course). Lewis et al (1998), using data from the 1993 UK Psychiatric Morbidity Surveys found that

income inequality is likely to have an adverse effect on mental health and increase the prevalence of neurotic disorder. Changes in social and economic policies that would reduce inequality should improve the mental health of the population (p.609).

Moser (2004) found a 'wide deprivation differential' in the prevalence of treated mental health problems in England and Wales. 'Men aged 25 to 44 years in the most deprived areas had rates of treated depression 50 per cent higher than those in the least deprived areas'. McConnell et al (2002) report higher prevalence rates in Derry,

Northern Ireland, than have been found in similar surveys in other parts of the UK, reflecting a higher rate of social deprivation. A great many treatment needs were unmet. Glover et al (1999) found that there was greater concentration of *severe* mental illness in deprived areas. However, Duncan et al (1995) found little regional variation in *low-level* psychiatric disturbance (measured by the GHQ). And Ebington et al (2000) found that 'the major influence on whether people seek the help of their family doctors for mental health problems is the severity of disorder. Although there are some social inequalities in access to family doctors, these are less important.'

In the promotion of better partnership working in mental health, the role of service user as partner is absolutely central (Robbins 2004; NIMHE 2003h). In describing what service users want from mental health provision, the recent SSI summary report offers an implicit dimensionality of need and also the dimensions over which service users should be able to exercise some influence, choice or control:

Immediate, appropriate help in a crisis, ... information, help with ordinary living, support with personal growth and development ... well co-ordinated packages of treatment, and a plan that takes account of their aspirations for the future: ... more therapeutic inpatient environments, and less experience of coercion and disempowerment...black and ethnic minority service users want equal access to the best available treatment, and culturally sensitive and appropriate services; ... choice about the kinds of treatment they receive (Robbins 2004 p.3).

Carers' wants are equally clear:

Carers want 24-hour, 7-days-a-week professional support, ... information about the illness ... and more education ... They want regular updates from professionals, and opportunities to learn personal coping strategies (p.3).

Social inclusion

In chapter 4, when considering services for older people, we noted a gradual 're-conceptualisation' of need since the early 1990s. There has been a parallel process in the mental health system, with increasing attention paid to the need for social inclusion. Of course, this has been a major focus across many areas of government policy since 1997. A major challenge for many people with a mental illness is stigma, which can lead to social marginalisation, neglect and disadvantage. Many are excluded from voting (Nash 2002). A number of countries have now initiated anti-stigma programmes and campaigns, but much remains to be done (Sartorius 2002). Even mental health professionals who themselves have used mental health services experience

discrimination from employers, colleagues and educators (Rooke-Matthews and Lindow 1998).

Much has been written on this topic in the UK (see reviews by, for example, the Sainsbury Centre for Mental Health 2002a, and the Citizens' Advice Bureau 2004), but the most significant document in the field was published last month by the ODPM (2004). The report

identified five main reasons why mental health problems too often lead to and reinforce social exclusion: stigma and discrimination ..., low expectations of what people with mental health problems can achieve, ... lack of clear responsibility for promoting vocational and social outcomes, ... lack [of] ongoing support to enable them to work, ... barriers to engaging in the community.

The ODPM calculated the 'social and financial costs associated with failure to prevent social exclusion among adults with mental health problems', emphasising the breadth and durability of some substantial cost impacts (pp.118-119). Their report set out a number of recommendations for policy and practice changes to tackle social exclusion, as we discuss later.

If there has been a change in public attitudes to mental health it has been growing acceptance of common mental disorders, but the stigma of serious mental illness remains. There have been many campaigns to address the stigma, discrimination and exclusion experienced by people with more serious mental health problems. Robbins (2004 p.12) describes Department of Health survey evidence 'that public attitudes have become less sympathetic to people with mental health problems over the last three years'. She points out that while there are many campaigns to combat stigma, few are evaluated. Fewer than half the local teams implementing the NSF in Autumn 2003 were evaluating their local anti-stigma strategies, and it is not clear how robust are the evaluations conducted by other teams.

The Psychiatric Morbidity Surveys of 1993 and 2000 revealed some changes over time (Meltzer et al 2002). There was an increase in the proportion of people with neurotic disorders who are educated either to degree or 'A' level standard, and a reduction in those with no qualifications. Among those with neurotic disorders there was an increase in the proportion who were economically inactive (unemployed and not seeking work), growing from 31 per cent to 35 per cent, but also an increase in those working full-time from 38 per cent to 43 per cent, though still markedly less than the 55 per cent employment rate for people without psychiatric disorders. There was a major fall in the unemployment rate from 14 per cent in 1993 to 4 per cent in 2000. There was a decrease in the proportions who were married or co-habiting and a corresponding

increase of being single. Among those with neurotic disorders the proportion married fell by 12 per cent. The proportion of people with neurotic disorder reporting one ADL difficulty rose from 33 per cent to 41 per cent, with the biggest increases found for practical activities (up 6 per cent), managing money (up 5 per cent) and dealing with paperwork (up 4 per cent). There was a 6 per cent increase of those who said they did not lack social support, suggesting a slight improvement in social networking or social support.

These are encouraging developments, but given the volume of information collected on individuals in these surveys it might be a little disappointing to government if these are the only payoffs over a six-year period resulting from the considerable attention and resources focused on identifying and meeting mental health needs. Perhaps the 2000 survey came too soon to pick up any real impacts from the Labour government's substantial investment.

Unmet needs

There are a great many unmet needs for better mental health and better mental health treatment and care. The large nationally representative Psychiatric Morbidity Surveys of 1993 and 2000 both record high incidences of undiagnosed need, untreated morbidity and social exclusion. The NSF reports that only about 30 per cent to 50 per cent of depression in primary care is recognised by GPs (and see Sainsbury Centre for Mental Health 2002). Jackson et al (1993) describe how the introduction of a new community multi-disciplinary team in a primary care setting doubled the rate of treated prevalence of mental health problems. Today, despite growing numbers of, for example, clinical psychologists many patients have to wait a long time for their psychological treatment. There is no national waiting list target for this service.

Even people in contact with services do not have all of their needs met by fragmented systems of services (Leese et al 1998). Ramana et al (2003) found 'some deficiencies in service aftercare for depressed patients, ... although unmet need was not high. Some aftercare failures reflect patient reluctance to receive further treatment, representing a challenge to overcome in patients entitled to autonomous choices' (p.109). Lockwood and Marshall (1999) conducted a pilot study in which they fed back information on the needs of people with mental health problems to CPNs. Significant improvements were seen in a number of unmet needs and the level of anxious/depressive symptoms. People are still 'falling through the net' (Harvey 1996; Gunstone 2003). And new needs may be emerging, yet to be adequately addressed, for example those presented by some refugees and asylum seekers (Turner et al 2003).

The challenge of unmet needs faces all agencies operating in the mental health system, singly and jointly. To give an example, Robbins (2004) notes that dual diagnosis (mental health problems with substance misuse and/or alcohol problem) 'is a significant and growing challenge for mental health services' (p.13). 'If ever joined-up work were needed, it is here'. Self-assessments by LITs apparently report encouraging progress in this regard.

We will have more to say on unmet needs when discussing targeting later in the chapter.

Funding and expenditure

NHS expenditure trends

It is difficult to be absolutely sure about the figures, not least because of the difficulties of identifying expenditure patterns and linking them to particular diagnoses, but NHS expenditure on mental health care is generally reckoned to have hovered around 12 per cent of total NHS expenditure for the last few years. It has grown from a lower proportion. In 2001/02, the last year for which we have been able to find Department of Health data, the proportion reached 13 per cent. This is an above-average percentage by the standards in most western European and OECD countries (see McDaid et al 2004 and the WHO *Atlas* database for details). Figures tabulated by the DHSSPS in Northern Ireland for 1999/2000 (taken from their website) suggest that – for that year at least – there was little difference between England (11.2 per cent), Northern Ireland (10.4 per cent) or Scotland (10.5 per cent), but the mental health proportion of total NHS expenditure was lower in Wales (8.8 per cent).

Mental health expenditure has an interesting distribution across the lifespan. A memorandum from the Department of Health to the House of Commons Health Committee broke down hospital and community health (HCHS) expenditure by sector and age. In 2001/02, across all ages, mental health services accounted for 12.7 per cent of total HCHS expenditure, but the proportion was as high as 23.6 per cent for the 16-44 age group and as low as 0.2 per cent for the 0-4 age group.

As total NHS expenditure has increased so has the absolute amount going to mental health (figure 5.1). In real terms, NHS mental health spending was 60 per cent higher in 2000/01 than in 1990/91. The main change in component spending has been on community health services, growing from 10 per cent to 20 per cent of total mental health expenditure over this period. Meanwhile the proportion accounted for by hospital inpatient services has fallen from 78 per cent to 60 per cent, although interestingly actual expenditure on inpatient services has grown in (price-adjusted) volume from £1855 million to £2303 million despite a policy emphasis on reducing the use of inpatient admissions where possible. We assume that the increase has been heavily influenced by the rapidly growing use of secure provision. In 1999/2000, for every pound of expenditure on mental health hospital services in England, 47p was spent on community mental health services (compared to 39p in Wales, 36p in Scotland and 28p in Northern Ireland).

Capitation funding formulae for the NHS now include a separate equation for mental health services, introduced in 1995/96 (Smith et al 1996). Of course, expenditure is not

hypothecated, which led Bindman et al (2000) to compare allocation with expenditure. They found that actual spending by health authorities diverged significantly from allocation, with the ratio between the two having a range from 0.55 to 1.48 in 1997/98. Relative under-spending occurred more frequently in deprived areas, and we have already noted the link between deprivation and need for mental health services. If the allocation formula was equitable (and one or two reservations were lodged in commentaries in the *British Journal of Psychiatry* following publication of the Smith et al article), then expenditure certainly was not. Moreover, Johnson et al (1997) point out that, in its initial implementation at least, the government used the formula only to allocate about three-quarters of total expenditure, to the disadvantage of inner city areas.

In the Bindman et al (2000) analysis, spending on mental health in the four inner London health authorities was considerably greater than the allocation. London's mental health expenditure has been high for some time (Chisholm et al 1997): indeed twice as high per capita than in Leeds, for example (Aziz et al 2003). The King's Fund review of mental health services in London in the mid 1990s found that purchasing authorities in the capital were spending 18.6 per cent of their total health budgets on mental health, compared to 12.8 per cent in other deprived city areas (Chisholm et al 1997). Reasons for this divergence included the higher rate of admissions in London, the higher cost of treating mentally disordered offenders (which is very high), the higher prevalence of dual diagnosis cases (psychosis and drug problems) and the shortage of acute beds leading to purchases from more expensive private hospitals (Johnson et al 1997; Goldberg 2000). The King's Fund argued that the allocation of NHS and local authority funds for mental health services did not take adequate account of social deprivation, and purchasers in London found themselves (often considerably) under-resourced.

A second look at London's mental health services, undertaken again by the King's Fund included a careful analysis by a team at the LSE/Institute of Psychiatry of patterns of expenditure by NHS trusts and local authorities (Aziz et al 2003). There was very marked variation in per capita NHS expenditure between the trusts (when spending was apportioned by borough), and component spending on priority activities such as assertive outreach and crisis resolution was also highly variable. Expenditure in London was still much higher than elsewhere in England. Within the capital, spending was closely correlated with various measures of deprivation.

Following publication of the NSF the government announced extra funding for mental health. Even if we disregard the possibility that there might have been some double counting – as with (as has been suggested) some other NHS spending figures – the amount actually spent falls some way short of expectations. Interestingly, although nationally the proportion of total NHS expenditure going to mental health has remained steady at around 12-13 per cent for a few years, Aziz et al (2003) calculated that NHS

mental health spending in London was 14 per cent higher in 2001/02 than in 1996/97, whereas total NHS expenditure in the capital was 28 per cent higher. The Sainsbury Centre for Mental Health (2003) found a similar situation. They audited a number of local 'mental health economies', examining each Local Implementation Team's financial data and Strategic Health Authority local deliver plans for 2003-2006. Planned increases in expenditure on adult mental health services, adjusted for inflation, were 3 per cent in 2002/03 over the previous year and 1.6 per cent in 2003/04, although actual spending was expected to fall short of this growth because of competing pressures. In both years, however, these rates of growth are much lower than projected growth in total spending, in fact less than half the rate, and below the long-term rate needed to implement the NSF. The implication would appear to be that mental health's share of total health care spending is about to drop. One frequently asked question is whether the resources released by the closure of the psychiatric hospitals has been reinvested in community mental health services. It is very difficult to provide an answer to this question.

Local authority expenditure trends

Expenditure on mental health services from local authority social services budgets is roughly one-fifth the size of NHS mental health expenditure. This is our estimated national average, although Aziz et al (2003) calculated that, at borough level, social services spending in London actually ranged from 23 per cent to as high as 79 per cent of NHS spending. (And recall Bindman et al 2000 finding that Inner London health authorities in 1997/98 spent considerably above the allocation.) These proportions are substantially higher than those reported by Evandrou and Falkingham (1997) for earlier years: personal social services spending on mental health as a proportion of hospital and community health services was 3.1 per cent in 1977, 4.7 per cent in 1985, 4.0 per cent in 1989 and 5.9 per cent in 1994.

As far as mental health is concerned, social care spending has grown faster than NHS expenditure over recent years. English local authorities spent about £330 million in England in 1994/95 compared with over £800 million in 2002/03. These figures are not adjusted for inflation, but figure 5.2 shows how the expenditure growth has been much faster than the rate of change in the retail price index and an index of social services pay and prices.

Within total social care spending the main changes in components have been the proportionate increases in expenditure on accommodation (nursing home, residential care home and supported accommodation), presumably as local authorities assumed responsibility for funding placements that previously would have been covered by social security support (compare figures 5.3 and 5.4). Earlier in the 1990s, the Mental Illness

Specific Grant (later the Mental Health Grant) was distributed to stimulate the provision of social care for people with mental health problems in the community, but it only ever represented a small proportion of total mental health spending (Audit Commission 1994). Otherwise there were few other specific injections of resources into mental health in that period, although the 1996 Challenge Fund made some additional resources available on a competitive basis.

Continued real growth is expected in England: 'Reported out-turn expenditure on mental health social care increased by 14 per cent during 2002/03, and the forecast for 2003/04 is 8 per cent higher than expenditure in 2002/03' (Robbins 2004 p.25). Mental health services accounts for only a small proportion of total social care spending by local authorities.

From figure 5.5 we can see that there has been much more modest absolute and real growth in social services expenditure on mental health in Wales compared to England, but again most of the growth is accounted for by accommodation services.

We have not seen any study of the geographical or administrative patterns of NHS and social care spending *nationally*, although Moscone and Knapp (2004) have been looking at spatial patterns of expenditure and their links with need. In London it appears that health spending and social care spending are positively linked: there is no evidence (from albeit limited analyses to date) of substitution between the two expenditure streams (Aziz et al 2003).

Multiple budgets, hidden dragon

When looking at the costs of supporting people with mental health problems it is all too easy to overlook a number of potentially substantial economic consequences, sometimes referred to as indirect costs, that fall to social care, education, housing, criminal justice and social security budgets. Often, there are also high costs falling to individuals with mental health problems and their families. For example, the Sainsbury Centre (2003a) recently calculated that the overall cost of mental health problems in England amounted to a huge £77 billion per year, 16 per cent of it arising as a result of care provision, 30 per cent because of lost productivity and the remainder because of reduced quality and quantity of life.

In more focussed research, Thomas and Morris (2003) describe some of these indirect costs for people with depression. They calculate that the effect of depression on employment (and hence on national productivity) is 23 times larger than the costs falling to the NHS. Calculations of this kind are never easy to make, and the method they used

may have exaggerated the true 'hidden cost', but the study reminds us of the wide economic impacts of some mental health problems.

An earlier study by Almond and Healey (2003) showed that (self-reported) depression/anxiety is the single most important cause of workplace absenteeism in the UK. The employment effects of depression are obviously most immediately felt by people with the illness, for employment is not only a major source of income and pension entitlements (and perhaps various fringe benefits), but also generates self-esteem, gives social identity and expands social networks.

A common feature of all mental health problems is their sizeable 'hidden' costs. A small sample study of children with conduct disorder found that only 16 per cent of the total cost was carried by the health service, the remainder falling to schools (special educational needs; 32 per cent of the total), social care (6 per cent), families (disrupted parental employment, household damage; 31 per cent) and the social security system (disability and similar transfer payments; 15 per cent) (Knapp et al 1998). Another study found that adults who, as children, had conduct disorder generated costs for a range of agencies that are significantly higher than the cost for people who had no conduct problems. Social care costs accounted for 11 per cent of the total public sector costs between the ages of 10 and 27 for the conduct disorder group, compared to 18 per cent of the much smaller total for people who had no conduct problems (Scott et al 2001). Criminal justice system costs accounted for the great majority of early adulthood public sector costs attributable to conduct disorder. Crime costs are also an important consideration when looking at the social impact of addictions. For every £1 of NHS expenditure on people referred for addiction treatment it has been calculated that another £3 is incurred by the criminal justice system and £10 by the victims of crime (Healey et al 1998).

One of the problems in increasingly performance-reviewed health and social care systems is that service professionals may find it hard to take decisions that are in the interests of somebody else's budget (including the service user's) if it can only be achieved at a cost to their own agency's resources. And, given that mental illness is known to be more prevalent in lower income groups, if the (hidden) individual and family costs are ignored when policy or practice decisions are taken, this might exacerbate the social exclusion of what is already a quite marginalised group.

Commissioning

We have come across surprisingly little evidence on commissioning arrangements for mental health services, and certainly not by social services agencies. Since 2002 PCTs have anyway had dominant responsibility for commissioning of mental health services.

Thornicroft and Strathdee (1996) compiled a useful edited volume on a range of commissioning issues a few years ago, and we commented in section 5.2 on the weaknesses in commissioning arrangements and skills in the early/mid 1990s. Today, concerns are expressed about 'weak commissioning' by PCTs, described, for example, as 'a key factor in the slow pace of modernisation of London's mental health services' (Levenson et al 2003 p.3). (See also Sainsbury Centre for Mental Health 2003, NIMHE 2003b, 2003c.) Light and Cohen (2003) discuss how to improve PCT commissioning of mental health by reforming the structure.

Secondary analysis of mental health care data collected in the mid 1990s revealed that actual price-cost margins appeared lower than would have been expected of a pure profit-maximising organisation, and that voluntary providers had greater market power than private providers but were less inclined to use it to set high price-cost mark-ups (Forder 2000).

Direct payments

Looking across all social care user groups the SSI and Audit Commission (2004) described the number of people 'able to choose to manage their own care' as 'lamentably low' (p.49). But take up by mental health service users does seem to be particularly low. 'Numbers receiving such payments have increased, but slowly and from a very low base' (Robbins 2004 p.2). Most service users and carers in the areas inspected by the SSI in 2002/03 'seemed unaware of the scheme' (SSI 2003 p.10). Nationally, the number of adults aged 18-64 receiving help with mental health support needs through direct payments was not much over 200 in March 2003. This was 2 per cent of all people using direct payments in September 2003. Few people from ethnic minority groups with mental health problems are accessing direct payments despite their potential for facilitating individual and culturally sensitive support. 'Studies have shown that inadequate leadership, a lack of awareness about and promotion of direct payments, and staff concerns about people's ability to manage payments have hindered greater take-up' (ODPM 2004 p.43). NIMHE (2003j) suggested further reasons, including emphasis in the 1996 Community Care (Direct Payments) Act on the needs of people with physical disabilities, the tendency for people with mental health problems to have contact with the NHS rather than with social services, tough eligibility criteria, and difficulties that people may have managing money when they are ill.

Direct payments can promote independence and inclusion in local communities by offering opportunities for rehabilitation, education, leisure and employment, but only if people with mental health problems are given the support to allow them to take them up.

Resource inputs

Staff numbers, recruitment and retention

The workforce challenges in the mental health field match those in other parts of the social and health care systems:

to improve workforce design and planning ...; to identify and use creative means to recruit and retain people in the workforce; to facilitate new ways of working across professional boundaries; to create new roles to tap into a new recruitment pool ...; to develop the workforce through revised education and training ...; to develop leadership and change management skills (NIMHE website, July 2004).

Given the rate of change in mental health, particularly the shifting balances between hospital and community, and between staffed accommodation and individual tenancies, together with directives to develop new forms of community-based specialist teams, a dynamic workforce is clearly needed. The NSF (Department of Health 1999f) included a section on workforce planning, education and training, and leadership (pp.108-112), setting out the implications of the new standards.

Across the country there are difficulties in recruiting and retaining qualified social work staff to work in the mental health area. 'Recruitment and retention in social care generally, and specifically in mental health services require urgent action' (Robbins 2004 p.33).

Organisations face continuing difficulties in recruiting and retaining staff in many areas. ... There is a lack of innovation to tackle long-term staffing issues. ... not enough is being done to address the longer-term shortages in staffing (Sainsbury Centre for Mental Health 2003c p.7).

Precise figures for most social care mental health posts are hard to find, but the Sainsbury Centre for Mental Health (2000) noted that vacancy rates in 1997 for officers and deputy officers in charge of homes for adults with mental health problems were 8 per cent and 13 per cent, respectively. The King's Fund review of London's mental health system also found major recruitment and retention problems across health and social care agencies (Genkeer et al 2003). Low levels of social worker involvement in the care of people leaving long-stay hospitals for permanent residence in the community were found in the English Care in the Community demonstration programme (Knapp et

al 1992) but considerably higher rates of involvement in an evaluation of a similar group of people in Northern Ireland (Donnelly et al 1994; McGilloway and Donnelly 1998).

A vicious circle of under-staffing and high turnover increases the pressures on staff that are in post. The costs of filling vacancies with agency staff and of recruiting new 'permanent' staff take resources away from the service. In this respect, recruitment and retention problems are not unique to social care, of course. The mental health clinical governance reviews by CHI (2003 p.12) noted 'significant staffing shortages, primarily psychiatrists and inpatient nursing staff have a major impact on clinical leadership and the quality of care. Inpatient staff express concerns about staffing levels, skill mix and use of locum, bank and agency staff.' Community-based initiatives are attracting nursing staff away from less attractive inpatient settings. However, 21 per cent of local implementation teams had 'no agreed workforce strategy and action plan in place across all agencies' (Mental Health Strategies 2004 p.28).

Back in the mid 1990s Wing et al (1998) had looked at the standards of care for people with severe mental illness, based upon visits to 11 sites. Among other findings was that social services departments were

involved in the preparation and implementation of commissioning strategies in all districts. Negotiations were generally at an early stage of development ... though there were examples where professional groups were working together in an effective and impressive way. Examples of lack of interaction could be seen in the implementation of hospital closure, the CPA, Section 117, care management and after care services. Similar problems were reported in operational arrangements, although more in management, delivery and provision of services than in working relations between staff. The latter interaction was facilitated when social services staff had specialist mental health skills (p.125).

Funding co-ordination between the NHS and social services was a cause for concern. It would seem that the picture has not greatly improved. The CHI (2003) clinical governance review of mental health trusts recently pointed to poorly integrated professions: 'cultural differences between health and social services staff in some areas are causing tensions at team level' (p.12).

Can multidisciplinary education help to break down the barriers? Reeves (2001) conducted a systematic review of the effects of inter-professional education on staff working in the adult mental health field. They found little rigorous evidence that inter-professional education is effective. Although 19 evaluations were found, the majority were weak in a number of design respects. Rolls et al (2002) describe a local partnership to deliver inter-professional education to nurses, psychologists,

occupational therapists and social workers (a Thorn diploma course, which is normally not provided on an inter-professional basis). No evaluation is provided.

A somewhat pessimistic picture has been painted of the future of mental health social work. For instance, McCrae et al (2004) describe how

social work failed to develop a strong professional voice to influence policy and practice. Practitioners have functioned according to imposed guidelines, and the political whims and fiscal constraints of their local authority employers. Social work has perpetually struggled with the issue of professionalisation, with influential voices from its own ranks opposing the pursuit of assumed expertise and professional power (p.315).

They point to the growing distance between mental health social workers and their social services (local authority) base, at each further step of integration into multidisciplinary teams. This might threaten the 'community focus of social work' as secondary care considerations come to dominate. The social workers in McCrae's sample were not opposed to integration, however. (An earlier discussion of mental health social work by Huxley and Kerfoot (1992) reported expectations among social services department staff that a more specialised social work service would develop as a result of the 1990 legislation, one that was better integrated with the health service.)

Robbins (2004) discusses the morale of mental health staff, pointing to the TOPSS England overview of the social care workforce, and a report by Huxley et al on working patterns of mental health social workers. Robbins highlights some of the findings from the Huxley et al study:

of the sample, about two-thirds of staff were covering work for absent colleagues; about one-third of the working week was spent on administrative tasks, partly because of limited administrative support; the GHQ rate (i.e. the measurable level of psychiatric distress) for social workers was nearly three times as high as in the general population; a large majority of social workers thought that their current grade did not reflect their duties at work; more than four out of ten feel under-valued at work (Robbins 2004 p.30).

Approved social workers

In the Huxley et al study cited by Robbins (2004) it was found that approved social workers (ASWs) reported greater job dissatisfaction than other social workers, and also higher levels of stress. The post of approved social worker was created following the 1993 Mental Health Act. Section 114 of the 1983 Mental Health Act specified that social

workers involved in applications for compulsory detention must be approved as having 'appropriate competence in dealing with persons who are suffering from mental disorder'. The ASW must 'satisfy himself that detention in a hospital is ... the most appropriate way of providing the care and medical treatment of which the patient stands in need' (Section 13). ASWs bring a non-medical perspective to the discussion of treatment, looking at the service user's social circumstances and needs.

Dunn (2001) describes three previous studies that looked at the activities of ASWs (Barnes et al 1990; Hatfield et al 1992; Sheppard 1990). All three studies were critical of the extent to which ASWs had embraced their responsibilities to look at a client's social context, to provide some kind of counterbalance to the medical view when considering compulsory treatment, and to look for possible alternatives to inpatient admission. Dunn then goes on to consider home treatment and the role of ASWs. She compared the circumstances and outcomes of Mental Health Act assessments in two areas, one of which had a psychiatric team whose aim was to provide rapid response and home treatment as an alternative to inpatient admission. She found few differences between the two areas, suggesting that both services were responding to all user groups. The area with the community treatment team seemed to be slightly better in terms of some of the process aspects, although potential differences between localities do not appear to have been fully adjusted for, or at least discussed.

Hatfield et al (1992) looked at the practices of ASWs in five local authorities, based on data collected in 1989-90. A great deal of variation was found between authorities in terms of organisational context and practice. In 2002/03, two-thirds of local authorities inspected by the SSI 'still have difficulty in recruiting and retaining ASWs, who undertake core statutory assessment functions on their behalf' Robbins (2004 p.29). Some authorities also reported difficulties in recruiting specialist home care workers. According to *Community Care* magazine (27 May - 2 June 2004), 'Many ASWs were leaving their jobs in droves to enter other careers amid fears that they would become redundant once the role of the mental health practitioner was established' under proposals for reforming the Mental Health Act.

Carers

Research suggests that, in supporting people with mental health problems, 'carers themselves are twice as likely to have mental health problems if they provide substantial care' (quoting ODPM 2004 p.4; they cite survey-based work by Singleton et al 2002). The emotional, health and economic impacts for carers can be substantial. The *National Strategy for Carers* launched in 1999 has begun to address these issues, and the mental health NSF and the *NHS Plan* both focused on this important area for policy and improved practice.

Standard Six of the NSF relates to the support of carers, arguing that, providing help, advice and services to carers can be one of the best ways of helping people with mental health problems. 'While caring can be rewarding, the strains and responsibilities of caring can also have an impact on carers' own mental and physical health, and these needs must also be addressed by health and social services' (p.69). The NSF reviews evidence on the needs of carers of people with mental health problems, and some of the strategies that can be used to support carers effectively. It also set out the need for health and social services agencies to ensure that carers have their caring, physical and mental health needs assessed. Carers should also be provided with information to help them meet their needs.

The Autumn 2003 Delivery and Improvement Statements show an increase both nationally and in every region in planned expenditure on the Carers' Grant 2003/04, both in terms of expenditure and numbers of carers helped, although on both counts what was achieved fell short of what was planned (Robbins 2004). About 7 per cent of expenditure and 7 per cent of carers receiving it are those supporting people with mental health problems, compared to an estimated 18 per cent of all carers who are reported to care for someone with a significant mental illness. Access to respite care is also reported to be increasing. However, inspections by the SSI found 'wider engagement with carers still very variable, carers' forums were less well developed, and the need for active communication with them around a care plan was not always fully appreciated' (Robbins 2004 p.17). Constraints on improving services for carers reported by authorities included 'staffing issues, financial difficulties and funding streams, IT problems which prevented the measurement of progress against plans, delays in multi-agency decision making, in training, and problems with the carers' assessment process itself.'

From their review of evidence, NIMHE (2003j) identified a number of reasons why recent policy initiatives have not always been translated fully into practice', including: carers being unaware of their rights to assessment; health and social care agencies prioritising support for users over support for carers; and people not actually seeing themselves as 'carers'. From the NIMHE review and our own search it seems clear that the literature on carers for people with mental health problems is far less extensive than that for carers for older people, although the issues raised are very similar. We have not been able to review the literature; see Arksey (2003), Pickard (2004a) and NIMHE (2003j) for coverage. Neither of these publications is based on a systematic review, but they helpfully 'scope' the research evidence on the effectiveness and cost-effectiveness of interventions for carers of (among others) people with mental health problems.

Services

In this section on services we first look at recent trends in the roles of hospital inpatient services since these have for so long dominated the landscape, both literally and figuratively. We then describe community-based accommodation, some of which can be seen as alternatives to inpatient care. The next sections look at important components of a community-based mental health system: first, day activities and employment support, then generic (CMHT) and specialist or functionalised teams (early intervention, crisis resolution and assertive outreach), and finally the models of case/care management and care programming. Finally, we consider the targeting of mental health services and mental health promotion. Throughout our primary focus is on social care, but as we have noted many times it is not easy to distinguish this particular input to what is an increasingly integrated system.

Before discussing hospital services it is helpful to summarise the overview of progress on social care perspectives written by Robbins (2004) for the SSI. She identifies 'a mixed picture, of change, some real achievement, and of areas requiring much more work' (p.1-2). In Spring 2003 local authorities were asked to describe their achievements in the year just ending, and the following emerged in relation to mental health services (again reported by Robbins 2004). About 70 per cent of authorities reported greater integration with NHS partners (e.g. integrated management structures, joint commissioning, single line management of CMHTs, more effective integrated care co-ordination via the care programme approach). Roughly 40 per cent reported increased numbers of people supported to live in their own tenancies; and a similar proportion reported increased support and advice for carers. About 15 per cent of authorities listed development in one or more of the following service areas: employment support schemes, greater service user involvement and crisis-oriented services. Authorities' own assessments of areas where they had made less progress included 'deferral or delay in setting up crisis resolution/home treatment teams, often because of NHS funding issues; and failure to reach targets for carers' assessments, often due to lack of dedicated staff or recruitment problems' (p.26). The main areas of risk to plans were financial and resource considerations and recruitment/retention problems, especially of approved social workers. There was a national shortage of ASWs. Other risk areas identified were in relation to various aspects of partnership or integrated working and mismatches between national and local priorities.

Hospital services

The most prominent trend in mental health care over five decades has been the shift away from hospital and towards community-based care. A more recent trend has been

the shifting balance between the public and independent sectors. Both trends have quite long histories, and both were given greater emphasis in the 1980s and 1990s (Goodwin 1989, 1997; Carrier and Tomlinson 1996). Hospital rundown accelerated, and the private and voluntary sectors were encouraged to provide much of the replacement community accommodation. Psychiatric inpatient bed numbers peaked in absolute terms at around 155,000 for the UK as a whole in 1954, around 100,000 in 1975 and had fallen to 38,000 in England by 2000 and to 32,750 by 2002/03. Recent trends are shown in figure 5.6. Relatively few of the large hospitals closed until the late 1980s, gradually releasing valuable capital resources (Lowin et al 1998).

Admission rates, on the other hand, increased in the 1980s and early 1990s, representing a substantial increase in hospital throughput (Ford et al 1998). More recently, if we look at hospital episode statistics over the period 1998/99 to 2002/03, we can see a fall in the number of admissions for people with dementia, substance misuse, mood disorders and neuroses, but not really any change in relation to people with schizophrenia (figure 5.7). On the other hand mean length of completed stay for people with schizophrenia has fallen slightly (figure 5.8), although it is still around 100 days. The emergency psychiatric readmission rate within 90 days of hospital discharge is falling, but is still in excess of 12 per cent (figure 5.9).

Despite the fall in inpatient provision, this service still accounts for a substantial proportion of total health and social care expenditure on mental health services.

Hospital closures

Although the target set in the 1975 White Paper, *Better Services for the Mentally Ill*, proved much too ambitious, the intentions were certainly important in bringing together a number of influential contributions to the rebalancing of care between hospital and community. The development of improved drug and psychosocial therapies were among the contributory factors in that shifting balance in the period prior to 1990. They were by no means the only reasons (Hall and Brockington 1991; Tomlinson 1991; Goodwin 1997). Communities have generally been described as having become more tolerant over recent decades (although recent Department of Health surveys of the attitudes of the general public would suggest a reversal, with growing antagonism and discrimination; see discussion in Robbins 2004). There is a better understanding of the preferences of people with mental health problems (if only because such preferences were so rarely sought in the past). Of course, there is still some distance to go. For example, a number of studies have demonstrated markedly different interpretations and of, and attitudes to mental illness in Britain's black and minority ethnic communities, and certainly vastly different experiences of the care process (see below). More generally, stigma remains an enormous challenge (ODPM 2004).

Another influence on closure was that the old psychiatric hospitals had become increasingly unacceptable, associated as they were with 'institutionalism' and restrictions on civil liberties. The old asylum model of care was a failure (Leff 1997; but see Weller 1993). Unacceptable standards were still to be found in some inpatient settings in the mid 1990s. A one-day survey of a random sample of all psychiatric inpatient wards in England and Wales in November 1996 revealed a number of unwelcome features: high occupancy rates (a mean of 111 per cent in Outer London, for example, and 99 per cent nationally; and see NIMHE 2003e, Audini et al 1999) although patients on 'home leave' reduced this to 86 per cent; some difficulties with bed management stemming from these home leave arrangements; a third of nursing staff employed on a casual basis; low levels of nurse interaction with patients; and two-thirds of women patients without access to women-only areas (Ford et al 1998). (See also Baker 2000, NIMHE 2003e.) 'Shabby, depressing wards – that would never be tolerated in medicine or surgery – were still commonplace in mental hospitals. Staff morale was low' (Department of Health 2001g p.4). Inspections today continue to find poor standards (CHI 2003).

The seemingly high costs of inpatient care help to explain some of the historical and current interest in reducing hospital-based services in favour of alternatives in the community. Good quality community mental health care requires services to be provided from a range of agencies, including social care, and the UK research evidence generally does *not* point to cost savings flowing from hospital closure (see section 5.7 below). However, an English and Welsh survey of almost 400 community accommodation facilities found costs to be significantly less costly than ongoing inpatient care (on long-stay or acute wards) even after adjusting for the fact that hospitals tend to accommodate people with more severe symptoms and greater needs (Lelliot et al 1996; Knapp et al 1997; Chisholm et al 1997). The key financial consideration, however, was that about 80 per cent of mental health expenditure was accounted for by less than 20 per cent of service users (Audit Commission 1986).

Holloway et al (2002) describe the process of closing the large mental hospitals as 'one of the recent triumphs of mental health services research in the UK' (or at least in England and Wales, since trends are slightly different elsewhere; see Prior and Hayes 2001 on Northern Ireland). Holloway and colleagues point particularly to the TAPS study in North London and other more modest research in the 1980s and early 1990s as providing evidence of broadly positive outcomes (and we discuss this evidence later in the chapter).

Delayed discharges

Although receiving less research, media or policy attention than delayed discharges for older people, the problems facing mental health service users who are ready to leave hospital but unable to find suitable move-on accommodation are equally severe (NIMHE 2003e; and see below). The reflections of the SSI and Audit Commission on seven years of joint reviews contrasted 1996 with 2003. In the earlier year,

integration of mental health services across health and social services was at an early stage for most councils. Service users experiences of hospital discharge were mixed and sometimes poor (p.30).

By 2003,

most councils had integrated health and social services teams in place and service users were seeing some of the benefits of closer joint working. ... Improving links with housing [departments] are creating housing with care schemes (p.30).

The NIMHE booklet rightly expresses surprise at the absence of evidence, and usefully summarises what is currently known. Shortages of suitable community accommodation feature regularly in the list of causes.

Continuing inpatient needs

As the hospitals closed, growing attention was paid to the 'new long-stay' who were beginning to accumulate in hospital beds. Lelliott et al (1994), for example, described how, in the early 1990s there were still a number of people who were experiencing protracted stays in hospital, despite the policy of bed closure and community care.

Many of these 'new long-stay' inpatients were considered to have complex needs and often behavioural problems. Some were considered difficult to place in community accommodation without 24-hour supervision. Nevertheless, experience with users leaving Friern and Claybury Hospitals who were considered by the hospitals to be 'difficult to place' pointed to the successful move into nurse-led or similar community units (Trieman and Leff 1996).

What attracted less attention initially, and may not have featured adequately in service planning for hospital closure, was the continuing need for some inpatient facilities for those people who had been discharged from long-stay hospital care into the community. Trieman et al (1999) described the 5-year follow-up of the Friern and Claybury Hospital

closure sample (about which, much more later). For the great majority the move to community-based living was successful. Nevertheless, these authors estimated that 9-10 inpatient beds were required (some in rehabilitation facilities) for every 100 long-stay patients discharged to the community. They note that the failure to build this ongoing need into hospital closure plans will have contributed to problems with overcrowded admission wards.

The London review of mental health services by Johnson et al (1997) found a number of districts and authorities that had run down hospital beds in order to develop community mental health teams and community-based services. However, this may have been

a two-edged sword: on the one hand, there are no longer enough beds left open to deal with the acute demand, and on the other there are now many more patients in the community who need care during remission, and compete for hospital beds during relapse (Goldberg 2000 p.58).

Bed occupancy rates were as high as 125 per cent in some areas, and there was a high threshold for admission. Unfortunately there was a marked shortage of 24-hour staffed accommodation in the community, and generally long delays for most community services. Low-support accommodation was available only in some parts of the capital, and 24-hour community services were almost entirely absent. Home treatment services, day care and employment support schemes were all under-developed. Services that offered culturally sensitive treatment to people from BME communities were very patchy, and primary care services in London were found to be significantly worse than in other large cities. There was clearly a need to develop better services in all of these respects, and also to put more emphasis on supported tenancies (with varying levels of support). The NSF also noted the difficulty of accessing acute inpatient services, particularly in some inner city areas such as London (Department of Health 1999f).

The balance of expenditure

Expenditure trends clearly illustrate the trend towards community-based care (Knapp 2004). Looking at the longer term picture, Evandrou and Falkingham (1997) use statistics reported by the Audit Commission (1986) and House of Commons Health Committee (1996) to calculate the proportion of total NHS and local authority social care spending on mental health that was accounted for by inpatient and residential services compared to community-based services (the latter including outpatient and day patient services). They report these calculations for four years. Inpatient and residential services accounted for the following proportions:

1977 – 90.7 per cent

1985 – 86.2 per cent

1989 – 79.9 per cent

1994 – 71.7 per cent

Our own calculations for 1997/98 2000/01 suggest figures of:

1997 – 57.6 per cent

2000 – 56.1 per cent

In London, total and proportional expenditure mental health expenditure by the NHS on long-stay inpatient services has fallen since 1996/97, as has expenditure on outpatient services, while expenditure on forensic services has grown rapidly (Aziz et al 2003).

Community-based care

There is clearly a relationship between the rate of hospital bed closure and the rate of opening of replacement accommodation and other community facilities. What is not at all clear is whether enough community facilities were opened in advance of the closure processes. Doubts were certainly expressed in the 1980s (House of Commons Social Services Committee 1985; Walker 1982; Thornicroft and Bebbington 1989; Goodwin 1997). Neither the NHS nor local authorities was especially keen to open new *in-house* community facilities, but – as for other user groups, and for similar reasons (the availability of uncapped social security funding, capital shortages in the public sector and the ideological preferences of central government) – reliance was instead placed on the private and voluntary sectors, with public funding. A suggestion that community-based care may still be inadequately configured comes from the findings of studies that point to high levels of inappropriate admissions (e.g. NIMHE 2003e; McDonagh et al 2000; Minghella and Ford 1997).

Poor coordination and under-provision

Until comparatively recently, a seemingly rather uncoordinated approach to the development of community facilities in some areas resulted in marked variations in the availability of public and independent sector care. One consequence was growth in the number of (expensive and unpopular) out-of-area transfers (Audini et al 1999; Health Committee 2000). There was – and still is – widespread under-provision of high-support accommodation (especially nurse-staffed 24-hour facilities) for people with the most

challenging needs, and suggestions that some community residential settings were offering poor quality care (Audit Commission 1986, 1994; Griffiths 1988; NHS Executive 1996; Johnson et al 1997; Shepherd et al 1997; Evandrou and Falkingham 1997; Levenson et al 2003). The NSF noted continuing shortfalls of 24-hour staffed accommodation in some parts of the country, particularly in London and some other areas with high needs for this kind of service, for people who are 'some of the most disabled and disturbed service users who would otherwise require long-term hospital care' (Department of Health 1999f p.51).

This may have been one of the reasons for large numbers of homeless mentally ill people in many towns and cities (Scott 1993), although cause and effect are hard to disentangle. Too many people were ending up in inappropriate seaside bed and breakfast accommodation (Barnes and Thornicroft 1993). On the other hand, relatively few staff working in hostels, group homes, residential and nursing homes had care qualifications. A survey in 1994 found that fewer than 15 per cent of workers in hostels with 24-hour waking cover had a nursing or social work qualification, and yet there appeared to be evidence that hostels were increasingly likely to be taking more severely disabled residents (Lelliott et al 1996; and see Garety and Toms 1990, Hamid et al 1995).

With the old asylums closing, and their resources not always reinvested in mental health care, the community too often became a bleak and neglected environment for people with mental health problems (Department of Health 1999f p.4).

Local authority-supported accommodation

Two psychiatric hospitals in North London that closed in the 1990s – Friern (in Barnet) in 1993 and Claybury (in Waltham Forest) in 1996 – were closely studied by the Team for the Assessment of Psychiatric Services (TAPS). A number of useful insights come from the TAPS study (summarised in Leff et al 2000; other sources of evidence are cited later). At the core of the research programme was a prospective longitudinal study of over 700 long-stay psychiatric hospital residents. People aged over 65 with a primary diagnosis of dementia were studied separately. For the purposes of the funding transfer from hospital to community services and for capital investment policies, *long-stay* was defined as continuous residence in hospital for at least one year. (Mean length of stay at the time people left hospital was 17 years.) Each long-stay resident was interviewed and assessed three times: in hospital; one year after each person left hospital for their new residence; and five years after leaving hospital.

It became apparent that community care for former Friern and Claybury inpatients was organised around a complex mix of accommodation settings, some provided by local authorities, some by district health authorities and others by large or small voluntary organisations and private sector bodies. Many new or refurbished facilities were opened. Over the period from 1985, the study observed growth in the number of joint ventures between the NHS and housing associations to establish public-voluntary sector consortia. One year after moving from Friern or Claybury, 60 people were living in hospital, 27 of them having transferred straight from one hospital to another, and the others readmitted as inpatients after a period in the community. Of the full cohort of hospital leavers, 15 per cent were living in local authority social services accommodation, and another 13 per cent in social housing (dominated by local authority provision at the time).

The national pictures in England and Wales can be seen from official statistics. The number of people with mental health problems supported by English local authorities has grown from under 10,000 to over 13,000 in just five years, while the proportion living in facilities staffed by authorities has fallen (figure 5.10). In-house provision is almost entirely used for temporary placements, whereas about half the local authority-supported admissions to independent accommodation were seen as permanent placements (figure 5.11). In Wales the number of mental health service users in residential homes grew modestly until the mid 1990s but appears to have declined since 1999 (figure 5.13).

The average cost of accommodation in care homes has grown over a five-year period, considerably faster than input cost inflation (figure 5.12). The increases in inner and outer London have been especially marked. This would suggest that average 'dependency' levels have been increasing over the period.

The sector balance

In the Friern and Claybury hospitals closure programme, one year after they left hospital, 40 per cent of the sample were accommodated in voluntary or private sector settings (Hallam et al 1995; Knapp et al 1999). The private sector provided only staffed accommodation in residential care homes and staffed group homes, whereas the voluntary sector (including housing associations) provided a wider range of accommodation types. Private residential care was largely provided by owner-managers; the corporate sector was not in evidence. Most were single-home operations, many having been opened by nursing staff leaving Friern or Claybury hospitals shortly after the closure plans were announced. Because very few residents

have any personal resources most private sector care homes are reliant solely on social security fees or contract payments by local authority or NHS purchasers. A number of the providers in the TAPS study reported recurrent losses because fees did not cover costs. Most of the voluntary sector homes were run by nationally-known organisations (or local branches of them), and hardly any were single-home organisations. In section 5.7 we describe the inter-sectoral differences in cost and quality uncovered by this study.

Evandrou and Falkingham (1997 p.235) chart the changing sector balance from 1974 to 1995, showing the inexorable rise in independent sector provision. The picture is different from that for care homes for older people. First, local authority in-house provision did not decline very much, indeed there was continued if modest growth in local authority staffed accommodation until the late 1980s. Tailing off thereafter was quite slow. Second, the public sector market share remained dominant for longer: local authority in-house staffed accommodation was greater in volume than the private sector until 1987 and greater than the voluntary sector until 1990. Third, the voluntary sector has a much larger provider role in the mental health sector than in accommodating older people (e.g. see Kendall and Knapp 1996; Kendall 2003).

The situation has changed markedly in the last few years. In-house provision has fallen in absolute and relative terms, and accommodation in the independent sectors has increased significantly (see figure 5.10 for England).

Accommodation priorities today

The NSF identified a number of accommodation settings that could be suitable for mental health service users, including – as well as fully independent settings – supported living options such as individual tenancies, short- or medium-term hostel accommodation with residential staff support, 24-hour staffed accommodation for people with a high level of need, inpatient hospital beds, alternatives to acute admission such as crisis houses, day hospitals or home treatment, and a range of secure provision (Department of Health 1999f). Local health and social care communities were asked to map this range of accommodation and other services. The National Beds Inquiry also looked at the range of provision of hospital-based care and the connections with support and care in community settings. Emphasis in government policy since then appears to have moved more squarely behind supported living options such as tenancies and shared housing, with less emphasis on staffed accommodation in the community.

The Supporting People programme has generally been seen as a great success, albeit an expensive one. (It will doubtless join the collection of costly unintended consequences of social policy.) It has opened up opportunities for people with long-term needs, including people with mental health problems, to access more independent living arrangements such as supported housing schemes. However, shortages of suitable housing in some parts of the country are severely limiting the extent to which service users can move to greater independence (Levenson et al 2003). And the question has been posed as to whether some local authorities have used the opportunity created by Supporting People to cut back their own housing and support expenditure.

The 2003 Delivery and Improvement Statements include a performance indicator measuring the number of adults with mental health problems helped to live at home per 1000 population aged 18-64. Between 2000/01 and 2001/02 there was a 23 per cent increase nationally, compared to only a minor increase from 3.2 per cent to 3.3 per cent the following year (see figure 5.14). Reflecting on these figures, the SSI noted that there were

significant regional variations, both in base rates and levels of change. ... This is a key target for mental health services and although there are encouraging indications of increased investment in services overall, the reasons for static or even falling numbers here merit local investigation (Robbins 2004 p.10).

Day activities and employment support

Supporting people with chronic health problems in community settings is obviously not unique to mental health. What distinguishes this field, as we have already discussed, is the multiplicity, heterogeneity and complexity of individual need, and the consequences for potentially a wide range of services. We therefore need to look beyond community accommodation to other services, and to arrangements put in place to coordinate them. The latter are discussed in the next subsection; here we focus on day activities and employment support.

Day activities

As the SSI review of progress by mental health social care services noted, day services are being 'refocused', and 'more emphasis is placed on training and acquisition of skills' (Robbins 2004). Certainly until the mid 1990s the number of day places was growing year on year.

Day activity services appear to have been little studied in the UK, and we found no relevant evidence for this review outside the health care sector except for the PSSRU survey reported by Beecham et al (1998). This study looked at the aims, characteristics, operational arrangements and users of a range of day settings in south east England. A similar study is now underway in Wales.

Employment support

The SSI reported last year that about 15 per cent of local authorities reported specific developments in one or more key service areas during 2002/03, including assertive outreach teams, day services and employment projects (Robbins 2004). The last of these is significant because for many years 'employment services' generally meant industrial workshops in the old psychiatric hospitals and some sheltered workshops in community settings. The approach today is more ambitious.

While most people with severe mental health problems want to work (90 per cent according to Perkins and Rinaldi, 2002), employment rates can be extremely low. The ONS Psychiatric Morbidity Surveys of 1993/94 found that only 27 per cent of people with depression living in households were in full-time employment and 16 per cent in part-time employment. For people with schizophrenia the proportions were lower, and of course none of these statistics takes account of the quite large numbers of people with severe mental health problems resident in hostels, care homes and hospital who are much less likely to be in paid employment. Loss of employment can equate to severely reduced income for people with mental health problems, as well as losses to social networks, pension and other entitlements. Work is also a normalising experience, allowing people to participate more fully in society and may in itself promote self-esteem and quality of life. In short, it considerably enhances the chances of social inclusion.

Both the SSI and the ODPM have recently criticised health and social care agencies for not doing enough to meet the employment needs of people who use mental health services:

Some employment support and leisure services were found in most areas, and some of these were much appreciated by service users and carers. ... While these developments are encouraging, they cover a very small proportion of the need for access to real employment opportunities which service users have consistently demanded. Stigma, public ignorance, and lack of employment support are keeping people recovering from mental health problems out of the work they need and want. This should be a priority area for councils and their partners (Robbins 2004 p.8-9).

Interventions specifically targeted on facilitating a return to work can be grouped into six types (Lehman, 1995):

- hospital-based work programmes;
- sheltered work;
- assertive case management;
- psychosocial rehabilitation, including prevocational training, transitional employment and volunteer placements;
- counselling and education; and
- supported employment.

The movement down this list of interventions reflects the changing ideology from 'train and place', a broad category that includes the first five types of programmes identified above, to 'place and train' (or 'place and support'). The policy emphasis in England today certainly appears to be moving towards this individual placement and support (IPS) model (e.g. see ODPM 2004) and away from specialist work schemes (Schneider and Hallam 1998). According to Becker et al (1994), who have pioneered this approach in the US, the core principles of supported employment are:

- (a) competitive employment in work settings integrated into a community's economy,
- (b) clients are expected to obtain jobs directly, rather than after lengthy pre-employment training,
- (c) rehabilitation is an integral component of treatment of mental health rather than a separate service,
- (d) services are based on users' preference and choice,
- (e) assessment is continuous and based on real work experiences and,
- (f) follow-on support is continued indefinitely.

The New Hampshire Dartmouth Psychiatric Research Centre in the US is credited with developing the individual placement and support (IPS) model that facilitates the placement of clients in a competitive job that is part of the community's economy, without extended preparation and which provides on-the-job support from 'job coaches'

or employment specialists. It is an integrated part of the entire treatment programme (Becker et al 1994). IPS projects appear to offer the best chances of cost-effectiveness (see section 5.7 for a summary of the evidence; Curran et al 2004).

The ODPM (2004) has suggested that the £140 million spent each year by health and social care services on vocational and day services for adults with mental health problems 'could be used more effectively to implement international evidence on what works, while providing a range of services to meet different needs' (p.97). Setting up Individual Placement and Support schemes would be one way to achieve this. Earlier access to mental health services would also be enormously beneficial, helping to prevent the escalation of more intractable problems. Paying more attention to the physical health needs of people with mental health problems would also address some health inequalities.

Generic and specialist (functionalised) teams

It is now time to take a deep breath. Any discussion of community mental health arrangements – what is put in place and whether it is effective – almost immediately gets embroiled in complex discussions. Terminological inexactitude, overlapping definitions, lack of fidelity to evidence-based models and necessary local adaptations of previous models to suit local contexts combine to make it very difficult to reach clear conclusions about what has been implemented and with what consequences. This is the main reason why an HTA-funded systematic review of the area focused on what were called *home treatment services*, a term intended to sweep up all the generic and functionalised models of community-based mental health care (Burns et al 2001; Catty et al 2002). One of the arguments of that review of the effectiveness and cost-effectiveness evidence was that some of the previous systematic reviews, for example those in the Cochrane library on assertive outreach, case management and community mental health teams, had been insufficiently strict in defining and delimiting the interventions, leading to erroneous conclusions. (See the similar critiques by Holloway 2001; and Rosen and Teesson 2001.) The NIMHE (2003d) booklet on community services reaches the same view, but then itself confused the picture by discussing the Burns/Catty systematic review under the 'crisis resolution' heading. Thornicroft and Tansella (2004) do likewise. This is indeed a tricky area.

The complications do not stop there. Once we introduce two of the key practices employed by community teams or services – case (or care) management and care programming – and recall the confusion about what these mean, how they differ and how they link with one another and with other treatment and support functions, then we descend into a near-impenetrable fog.

The simple message to emerge from these complex debates is that community interventions, especially in an area as difficult as mental health, are by their very nature rather different from medications, surgical procedures, medical appliances or even psychological therapies. When operationalised locally, they are inevitably, perhaps inherently context-bound.

What are we to do here? In this section of the chapter we are concerned with service developments, and we will endeavour to describe what changes have been made to the organisation of community teams of different kinds. We will then provide a separate account of case management and the care programme approach. In section 5.7 on outcomes and cost-effectiveness we will first pull the evidence together across the different models of support (drawing heavily on the HTA review by Burns et al 2001 to which we contributed, so we may be biased in our preferences), and then pick out evidence for specific models that appears to be robust. The health warning that we need to issue immediately is that experts in this area do not agree on how to categorise the models or arrange the evaluative evidence, and we (as comparative non-experts, even though we have participated in quite a few evaluations in this area, and also one of the systematic reviews) can certainly not claim to be in any position to do so. Having entered those heavy caveats, what is the evidence on service development?

Community mental health teams

Community mental health teams (CMHTs) started to appear in the 1970s as the multi-disciplinary means by which non-hospital mental health services would be coordinated and delivered. The 1990 legislation and accompanying guidance set out an aspiration for them that they would 'provide a service in which the boundaries between primary health care, secondary health care and social care do not form barriers seen from the perspective of the service user' (quoted by Gulliver et al 2002). Their role was 'legitimised by the introduction of CPA in the early 1990s' (NIMHE 2003d, pp. 3-4). Boundary problems did not disappear (Gulliver et al 2002).

Despite some initially encouraging evidence of good quality care (Gater et al 1997), there were criticisms of CMHTs. The NIMHE (2003d) policy booklet quotes Chalk (1999): 'a poorly constructed team with a muddled purpose, expectations and achievements in terms of both service provision and team integration'. Other criticisms were of over-large caseloads, ambiguous aims and poor targeting to the disadvantage of people with the most challenging needs (Patmore and Weaver 1991, Sayce 1991, Ward et al 1999; NIMHE 2003d). The considerable challenge of marrying NHS-led care programming with local authority-led care management in a resource-constrained environment also fell to CMHTs (Onyett et al 1997; NIMHE 2003d). It was not surprising, therefore, that proposals should be announced in 2001 to move away from

sole reliance on generic CMHTs to specialist community teams (see below), and sought to clarify the links with primary care.

The Department of Health issued guidance on community mental health teams in 2002. The guidance identified three distinct functions performed by CMHTs:

giving advice on the management of mental health problems by other professionals - in particular advice to primary care and a triage function enabling appropriate referral. Providing treatment and care for those with time-limited disorders who can benefit from specialist interventions. Providing treatment and care for those with more complex and enduring needs (Department of Health 2002 p.5).

The guidance recommended that CMHTs 'should be singly managed teams including both health and social care. Social workers in the team should be co-located to the same office and use the same notes' (p.16). The guidance suggested that a team carrying a caseload of 350 service users, half of whom have severe long-term disorders, would perhaps have eight whole time equivalent care co-ordinators, each with a maximum caseload of 35. Of these staff, two or three would be social workers, including ASWs. These social workers 'need to maintain strong links with social services as well as being fully integrated team members' (p.20). In fact, they are not doing so. CHI (2003) found

considerable variation, sometimes within the same trust, in the level of integration of CMHTs. Some community services are embryonic and only now incorporating social care members. In some areas integration is formal only, with separate policies and protocols for health and social care staff. In other areas there is a high level of operational and cultural integration (p.5).

However, Firth et al (2003) describe the recommendation for CMHT members to operate with a maximum caseload of 35 as unrealistic 'for a clientele usually presenting with prominent risk factors and complex needs, often reflected in high service dependency' (p.260). The authors argue for re-emphasis of a socially constructed model of mental disorder, which would run counter to the 'medical' model in the DH guidance.

Specialist mental health teams

The NSF argued for a concerted, nationwide departure from reliance solely on generic teams building on generally positive outcome and cost-effectiveness findings from

evaluations of similar such teams already in operation in a few parts of England and in other countries (see section 5.7).

Community-based assessment and treatment may be effective alternatives to hospital admission, with crisis resolution and sustained home care for people with serious mental illnesses. This can be delivered either by members of the CMHT or a specialised home treatment or crisis resolution team. It may involve intensive work with a single service user over a period of several days. ... There is evidence that, for black people, who tend to be more critical of mental health services, home treatment is more acceptable than a hospital admission, and there is better continuing engagement with services. Involving service users in the service planning process can help to develop more acceptable and culturally sensitive services (Department of Health 1999f p.51).

The NHS Plan and the Policy Implementation Guide (Department of Health 2001f) took up the detail and at the same time plumped for a 'functionally differentiated service model' of three specialist teams (most likely constructed on a multidisciplinary basis) to replace or complement generic CMHTs:

- an early intervention psychosis service to manage new cases;
- a crisis resolution team to reduce the number of inpatient admissions (the label actually applied was 'crisis resolution and home treatment team', but we shall drop the last three words to avoid the confusion that besets the NIMHE 2002d booklet in linking this specific team model with more general community-based approaches); and
- an assertive outreach team to support service users who would otherwise be poorly engaged with services and probably not taking their medications.

CMHTs would not be abandoned. They would continue to have an

important part to play in supporting service users and families in community settings. They should provide the core around which modern mental health services are developed. Their responsibilities may change over time but, working with primary care, they will be the main pathway for referrals to the more specialist teams (Department of Health 2001g p.11).

The 2001 guidance tried to clarify the respective functions of the three new types of team, something that was needed given the somewhat variable interpretations of function, terminological imprecision and organisational confusion to which we have already alluded. What then are those functions?

Early intervention teams 'provide intensive support and help that every young person who develops a first episode of psychosis needs. These teams ... will base their belief that engagement, rather than compulsion, is the key to success' (Department of Health 2001g p.10). It is widely held that the earlier the identification of symptoms and associated needs the better the outcomes, and NIMHE (2003d) claim that there is 'increasing theoretical and practical justification' (p.5), although there appears to have been little evaluative research to date (Thorncroft and Tansella 2004). One practical challenge in establishing an early intervention team is to that the prevalence of new cases will be quite small, so that each team might need to serve a population of about one million, raising questions about how to coordinate activities across PCT and mental health trust boundaries (Sainsbury Centre for Mental Health 2002; NIMHE 2003d).

Crisis resolution teams have been established to provide an alternative to inpatient admission for someone needing urgent mental health care, and so avoid the disruption to home, work and social networks that can follow. These new teams provide assessment and intensive treatment at home (Department of Health 2001g), serving populations of perhaps 150,000. They are expected to operate a 24-hour service, seven days a week, but concerns have been expressed about the difficulties of doing so in rural areas, as well as about the safety and the difficulties of integrating these crisis activities with other services (Owen et al 2000; Ryan et al 2001; NIMHE 2003d).

The work of *assertive outreach teams* is targeted on people who are 'frequently admitted to hospital, often compulsorily, but sometimes lose touch with services soon after discharge. Often they suffer from dual diagnosis of substance misuse and serious mental illness. A small proportion also have a history of offending' (Department of Health 2001g p.10). The NSF made suggestions for how these teams would operate, and at the same time made plain the case management tasks that are fundamental to their mode of operation:

Assertive outreach or assertive community treatment is a form of intensive case management that provides a clinically effective approach to managing the care of severely mentally ill people in the community. Staff providing comprehensive assertive outreach care for clients will visit them at home, act as an advocate, and liaise with other services such as the GP or social services. Help is usually needed to find housing, secure an adequate income, and sustain basic daily living - shopping, cooking and washing, for example.

Opinion varies about the optimum staff-client ratio for assertive outreach. In some settings the ratio is as low as 1:12 (Department of Health 1999f p.47).

The assertive community treatment (ACT) or outreach model is most closely associated with the well-researched approach developed in Madison, Wisconsin by Stein and Test (1980). There are dozens of similar definitions of how assertive outreach teams operate (and tests of fidelity to the evidence-based approach), but we do not need to go to that level of detail except to note that a number of evaluations claiming to be looking at 'assertive outreach' were actually looking at models that departed from the original approach in quite significant ways (see discussion in NIMHE 2003d, for example, and see section 5.7). An assertive outreach team in England might be expected to serve a population of about 250,000.

Looking broadly over the model of functionalised community teams, the SSI and Audit Commission (2004) reported growth in the numbers of crisis resolution and assertive outreach teams, and moves to extend the hours during which these services were available. In a speech in July 2004 to a Sainsbury Centre conference, Rosie Winterton reported that 253 assertive outreach teams are now in place (compared to the NHS Plan target of 220), 174 crisis resolution teams (compared to the target of 220) and 41 early intervention (community-based support and treatment) teams. The review of current spending patterns by the Sainsbury Centre for Mental Health (2003) found that budgetary constraints facing LITs are slowing down the development of early intervention, assertive outreach and crisis resolution services. And the recent King's Fund inquiry into London's mental health found that only a third of LITs in the capital had set up crisis resolution teams (Levenson et al 2004).

Case management and care programmes

Case management models have been tried in US mental health systems for at least thirty years, and as we have seen some of the specialist arrangements for community care (notably assertive outreach) embody good case management principles and practices. Again as we have pointed out already, imprecision in the use of terms and the attribution of successes and failures makes it less than straightforward to describe what has been implemented and achieved in the co-ordination of care for individual mental health service users. Another complication is that case (later care) management developed further and faster in the UK in the (almost) parallel field of social care for older people (see chapter 4). Third, while social services departments were contemplating the introduction or expansion of models of care management in response to the urgings of the 1990 Act, the government surprised many people in 1991 by introducing the care programme approach, which looked more like a form of clinical

case management. In consequence, there is a great deal of overlap between the aims and roles of care management and care programming.

Models of case management

To try to impose some order on the plethora of approaches that are in use, it is helpful to draw on the useful review by Simpson et al (2003). These authors identify a number of different case management models. They first distinguish three types of standard case management, one which they call *brokerage case management*, and another *clinical case management* models. In the former, the case manager acts as a broker, advocate and purchaser of services, but is not a provider or therapist. The model has rarely been adopted within the UK, where most care managers (care coordinators) have professional qualifications. The clinical case management model emphasises the therapeutic relationship between staff member and service user, and that relationship allows the case manager to assess changing needs and make arrangements to broker or purchase or otherwise access services to meet those needs where necessary.

A third category is a *rehabilitation-orientated model of case management*, and Simpson et al discuss the strengths model. This grew out of the social work field 'in response to concerns that traditional approaches to psychiatric treatment and case management over-emphasise the limits and impairments associated with psychiatric illnesses and underestimate the personal assets that patients can harness towards achieving individual goals' (p.474; they cite Mueser et al 1998). This approach also recognises the potential 'resources' within the community to be developed in support of the service user, and also help for example to reduce social exclusion and stigma.

Simpson et al (2003) then go on to discuss two forms of intensive case management models. The first is the *assertive community treatment* model of Stein and Test (1980) that we have discussed already. Team working is at the heart of this approach (in comparison to the individual responsibilities of case managers), and teams are often multidisciplinary, working in the home or the place of work of service users, rather than in clinics or hospitals. Caseloads would generally be small and the 'assertive' part is because staff will actively engage with service users who are reluctant to engage with services. Medication adherence is also emphasised. The other model is generally simply called *intensive case management*, effectively a form of clinical case management with smaller caseloads. There has been a lot of debate as Simpson et al note as to whether intensive case management is identical to ACT (e.g. see Rosen and Teesson 2001; Thornicroft et al 1998; NIMHE 2003d). One difference, however is that intensive case management teams do not usually share caseloads.

The care programme approach

Introduced in 1991, the care programme approach (CPA) was intended to keep people in contact with services. Tasks included assessment, care planning, keyworker support and regular reviews. But the CPA has come in for criticism. Based on data collected in 1995/96, Bindman et al (1999) found that prioritisation for the use of the CPA appeared not to be closely linked to need, and inequitable treatment resulted. Schneider et al (1999) surveyed mental health trusts in 1997/98, also finding significant differences across England in the involvement of professionals, carers and users in the various stages of CPA, but some high levels of 'harmonisation' between health and social services in some areas. Simpson et al (2003) concluded that

The CPA remains unpopular and is seen as overly bureaucratic.... It has been undermined by insufficient resources ... and unrealistic and unmanageable temporal and logistical expectations. ... It continues to be unevenly implemented ... and is unviable or ineffectual to many service users. ... Operation of the CPA often exacerbates interdisciplinary tensions within the multidisciplinary teams (CMHTs) required to deliver the programme ..., and the policy lacks an underpinning philosophy of care that might have unified teams. ... To a great extent and for a range of reasons, the CPA has failed to fulfil its true potential (Simpson et al 2003 p.472).

Each ellipsis in the above quote from Simpson is a reference to British evidence in support of the criticisms levelled at the CPA. One of the problems is that the CPA

does not appear to have been developed with any particular model of case management in mind. Rather, it takes a broad-brush approach, with the programme's content and guidance too bland and non-specific ..., and there is no underpinning philosophy of care (p.477).

Carpenter and Sbaraini (1997) found that most mental health service users 'were very positive about their relationships with their care manager (psychiatric nurse or social worker). However, few had been asked their views about their admission to hospital or knew about complaints procedures'. On the other hand 'users with a care programme felt more involved in planning their own care and treatment, had more choice and were better informed about rights and services. ... [They] were more likely to have been asked whether they wanted a carer involved and also to report that their carer had discussed their care with mental health professionals to the extent that they wished' (p.1).

The NHS Centre for Review and Dissemination (2001) review that followed directly from the NSF concluded that the CPA was not an effective intervention.

An unwieldy two-brained dinosaur?

In an editorial, Tyrer (1998 p.2) summed up the views of many of England's community mental health system: 'an unwieldy dinosaur with its health and social care brains working independently'. The earlier comments by Hadley and Goldman 1995 discussed in section 5.2). There were clearly some problems in integrating the two approaches (Schneider 1993).

Hughes et al (2001) looked at the delivery of care management and the CPA approach for older people with mental health problems, based on a national survey of local authorities (response rate 77 per cent). The application of the CPA was found to be patchy, and there was clear evidence of duplication of care management arrangements. London boroughs generally had a higher degree of service integration than other authorities.

In another study largely carried out in the late 1990s, Carpenter et al (2004) found significant differences between four localities in the extent to which a care programme approach and care management were integrated and targeted. a finding that has been reported subsequently by others. The common approach emphasised across the two parallel systems included 'systematic assessment, an agreed plan of care and treatment, the allocation of a key worker/care manager and regular reviews. The key principles include multi-disciplinary team working, involving carers, and ... the involvement of users in their own care and treatment' (p.315). Carpenter et al found that users with severe and enduring mental health problems expressed generally positive opinions about community mental health care and specifically the CPA. Some found the process of care programming to be empowering. These researchers nevertheless point to the need for improvements, particularly in some of the localities they studied. Users expressed a preference for closer integration of health and social care services, as was subsequently (to this study) required by the NSF. Carers and community mental health workers also expressed a preference for closer integration, as described in other papers from this same study (Schneider et al 2001; Carpenter et al 2003).

Preparation of the NSF gave an opportunity to review what had happened. The NSF argued that 'care planning and the delivery and regular review of a comprehensive package of services for people with severe mental illness is a multi-agency endeavour' (p.45). The dangers of fragmented, dislocated and therefore ineffective and inequitable services is obvious, and in another document that same year the Department of Health (1999d) argued for the full integration of social services care management and the NHS CPA. There should be two levels of CPA:

[standard CPA] for individuals who require the support or intervention of one agency or discipline, who pose no danger to themselves or to others, and who will not be at a high

risk if they lose contact with services; and enhanced CPA for individuals with multiple needs, and who need to be in contact with more than one professional or agency (including criminal justice agencies). This group needs more intensive help from a range of services, and may have more than one clinical condition, or a condition which is made worse by alcohol or drug misuse. They will include those who are hard to engage, and with whom it is difficult to maintain contact. Some individuals would pose a risk if they lost contact with services (Department of Health 1999c, p.53).

For other official urgings to achieve better integration see Department of Health (1995, 1996, 1999h). In 2001 the Department was still of the view that 'in many areas the CPA was not working' (2001g p.8). And the clinical governance reviews by CHI (2003) found 'inconsistent application' of the CPA across trusts.

Targeting

Despite the encouraging developments in many spheres, the impression remains from research, audit and inspection that much more could be done to target those services better.

From inspections there is evidence of many good, individual services promoting and supporting the social care of service users. But the co-ordination which would make these initiatives work together as a coherent strategy against social exclusion is often lacking. At the same time, individual, often good services targeting the employment or accommodation of service users are currently inadequate to meet demand. Meeting these needs should be a priority for councils and their partners (Robbins 2004 p.2).

Deficiencies in the targeting of services on needs have been noted in at least three respects relevant to this discussion of social care: in relation to the links between accommodation settings and other services; in the under-development of prevention; and in failing to identify and appropriately address the needs of people from BME communities.

Sector bias

Reanalysing data from a large cross-sectional survey of all types of residential accommodation for people with mental health problems, Lucas et al (1998) found that where you live – the sector in which your accommodation is located – is an important influence on the number of service contacts made, even after adjusting for personal characteristics, including a number of needs-relation factors. People living in lower-

staffed facilities tended to have higher numbers of community-based service contacts. People in voluntary sector facilities used fewer services than those accommodated elsewhere, and it would appear that this did reflect under-use (i.e. poor targeting). Earlier work on the closure of Friern and Claybury hospitals and also on the Care in the Community demonstration programme had similarly found that the managing sector of a person's accommodation was a significant predictor of how many services were used, of what types and at what cost (Knapp et al 1992; Hallam et al 1995).

A similar finding emerged from the study of more than 3000 people in eight English localities by Huxley et al (2003), 400 of whom were followed up 5 months later. Data were collected in 1998. Health and social care staff tended to refer people with mental health problems to services in their own organisation. 'Both services continue to operate separate gate keeping in the form of assessment and eligibility (or severity) determination. Patients and other community referral agents can access either the health provider or the social care provider... A 'one-stop shop' where all services could be accessed at the same time and location was very uncommon' (Huxley et al 2003 p.48). Over time, however, professionals recognised the broader needs of their clients and the researchers observed a considerable increase in access of services across the health/social care divide. Integration of a sort was therefore achieved, but not in the most efficient manner. Whole system approaches were not in evidence.

Prevention

NSF standard one relates to mental health promotion and the promotion of social inclusion of people with mental health problems. There is a good discussion of many of the issues that people with mental health problems face in this respect. Paton et al (2001) describe the prevention programmes launched in England to reduce the incidence of depression. Levenson et al (2003), however, are critical of the attention and resources devoted to prevention locally in London.

BME groups

Some good work is reported [from LITs] in relation to work with carers: less, in relation to culturally appropriate services for black and ethnic minority service users (Robbins 2004 p.2).

As we have found for other service user groups, people from black and minority ethnic groups appear to be less well supported. In particular, there is evidence of under recognition of needs, over use of inpatient and compulsory treatments, differences in attributions of illness and lower satisfaction. The study by Commander et al (1997)

illustrates the poor targeting and is typical of what has been found in a number of studies. A third of the people with mental health problems in an urban area did not consult a GP, and half failed to have their problems recognised by their doctor. Access to specialist psychiatric services was very restricted. But people from BME communities had worse access and recognition rates. In a second paper, Commander et al (1997a) concluded that 'the major impediment to Asians accessing care occurred at the interface between primary and secondary care, whereas the most striking feature for Blacks was the poor level of case recognition by GPs'. Subsequently, Commander et al (1999) showed that ethnicity influenced the complexity of the care pathway:

Asian and especially Black patients had higher levels of both involvement with the police and compulsory detention than their White counterparts. ... Black patients, as compared to Asian but especially White patients, were more often detained in hospital against their will, confined to the ward and treated within a secure environment (p.484).

A selection of other studies can be described. McGovern and Hemmings (1994) followed up 33 white and 42 second-generation Afro-Caribbean patients 5-10 years after their first admission to inpatient care for psychiatric treatment. No differences by ethnic group were found in relation to user satisfaction, conceptualisation of illness or attitudes to treatment. Black relatives were more likely than white relatives to attribute the illness to substance misuse and to see services as racist, and relatives and users both saw a need for culturally sensitive services.

ui et al (2001) could find no difference between Punjabi and 'English' primary care patients in the prevalence of common mental disorders, but found that diagnosis was more likely to be correct for the 'English' group, although less good for women than for men within that group. Mclean et al (2003) examined the institutional, cultural and socio-economic exclusion of African-Caribbean people with mental health problems in the UK. Interviewees described the racist mistreatment they had received by mental health services, which discouraged their early access of treatment and perpetuated inequalities.

There is evidence from many sources of imbalances in the utilisation of certain services by people from different ethnic groups, and of course a charge of institutional racism was levelled at the NHS quite recently. Bhugra (1997) reviews some of the evidence of over-utilisation of hospital services, as well prisons and special hospital, as examines some of the issues for multiethnic mental health services. Knapp et al (2004) found that people from black ethnic groups had a higher likelihood of using inpatient services, standardising for all characteristics including morbidity, when focusing on people with schizophrenia. A number of other studies have reported that African-Caribbean people have a higher likelihood of accessing psychiatric services via the police or through

compulsory treatment. (See the *Evidence Review* by Morgan et al 2004). This paper argues for a fresh approach to the interpretation of ethnic variations in the pathways to psychiatric care in order to develop more constructive bases for policy formulation.

Sheikh and Furnham (2000) found significant differences between 'British Asians, Westerners and Pakistanis' in 'casual attributions of mental distress', which would influence attitudes towards referral and treatment. And Khan and Pillay (2003) found different attitudes towards home and hospital treatment among South Asian and white residents in a small sample study in England. UK-born African-Caribbean users with psychotic disorder gave significantly worse satisfaction ratings of mental health services than white users in a South London study (Parkman et al 1997). Hunt et al (2003) argue that mental health services need to improve the ways in which they address the complex health and social needs of people with severe mental illness from BME communities, in order to reduce the number of suicides.

Looking across the full span of social care, the SSI and Audit Commission (2004) summary of the joint reviews concluded that

Services sensitive to the needs of black and minority ethnic communities were generally underdeveloped in 1996. ... The picture ... in 2003 remains mixed. ... Service development has certainly lagged way behind stated objectives contained in positive equalities policies and strategies (p.31).

Not surprisingly, therefore, in a July 2004 speech to a Sainsbury Centre conference, Rosie Winterton stated the government's commitment 'to the largest and most comprehensive programme ever to improve black and minority ethnic mental health'.

Outcomes and cost-effectiveness

This next section on evaluation evidence has been unusually difficult to write, primarily because so little of it is social care-specific. There are certainly social care inputs to some of the interventions for which there is a good evidence base, but whether social care is an 'active ingredient' is impossible to tell. Moreover, the very limited volume of research on social care mental health (specifically) has led to a very limited evidence base for establishing and monitoring standards whether 'routinely' by providers or commissioners or by central government agencies. Consequently, while evidence coming from inspections and audits, and the performance measures they generate and employ, is informative it is also generally inconclusive. For example, as will be clear from the number of times we have quoted it in this chapter, some very helpful insights come from the recent SSI review of social care contributions and roles in supporting people with mental health problems (Robbins 2004). But that review discusses neither service user outcomes nor cost-effectiveness. The focus instead is on policy objectives, the government's 'vision' for mental health, the processes of supports, and the service models.

Outcome dimensions

What outcome dimensions should we employ when considering social care mental health services? In a broader evaluative context, outcome measurement would aim to cover:

- mortality, since people with mental health problems have higher than average death rates, particularly from suicide (Harris and Barraclough, 1998)
- reductions in symptoms,
- improvements in personal and social functioning and contacts (linked to a 'participation' approach to social inclusion),
- access to employment and community resources (linked to a 'rights' approach to social inclusion),
- quality of life from the service user's own perspective,
- satisfaction with services,
- carer quality of life,

- wider societal outcomes such as exposure to antisocial behaviour or risk.

Social care interest in the mental health field has a slightly narrower set of concerns perhaps. The current priorities for social care in mental health as described by the SSI are:

listening to and treating with respect the views and aspirations expressed by service users and their carers; combating stigma and discrimination; seeing the person seeking support as a whole; respecting diversity; understanding social exclusion and tackling it on every possible front. ... [This must be done] in partnership with a wider range of agencies and interests than ever before [which] make these values a critical component of modern mental health services (Robbins 2004 p.5).

The NSF set out recommendations for outcome indicators for severe mental illness, which we list in full in an appendix at the end of this chapter (Department of Health 1999f). These do include a few 'true' outcome indicators, rather than simply measuring activity or process, although not all have been implemented.

In the sections that follow we endeavour to review the evidence that is relevant to our current focus on social care. Where possible we have drawn on Cochrane or other systematic reviews. We have tried to focus on UK evidence, although sometimes it is necessary to look a little wider. More Cochrane collaboration reviews have been carried out in the mental health field than we need for this report. We do not discuss those that involve drug treatment or ECT here. We also exclude psychological interventions, even though treatments such as cognitive behavioural therapy (CBT) could in principle be delivered by social workers. (It is in the US but we do not think that it is in the UK; see for example the Cochrane review by Cormac et al (2004; last updated October 2001) on the effectiveness of CBT for people with schizophrenia.)

We discuss the evidence under the following heads:

- mental health prevention or promotion
- hospital closure
- short-stay hospital admissions
- community care arrangements (including assertive outreach, crisis intervention, case management)
- supported housing

- employment initiatives
- day hospitals
- non-medical day care
- life skills programmes.

First, however, we summarise the conclusions from a review of reviews commissioned by the Department of Health after publication of the NSF.

Evaluative evidence – a ‘scoping’ review of the NSF

The Centre for Reviews and Dissemination (CRD), University of York, completed a ‘scoping review of the effectiveness of mental health services’ in 2001, specifically structured by the standards laid out in the mental health NSF. The review looked only at other systematic reviews, not at original studies. It was also confined to systematic reviews that evaluated mental health promotion or mental health service delivery or organisational interventions, and excluded therapeutic interventions aimed at individuals, thus excluding interventions of psychological (face-to-face, telephone- or computer-based) and pharmacological therapy, for example.

The conclusions from this CRD review of reviews are quite similar to the conclusions that we draw here from looking primarily at original studies (at least for those areas most relevant to social care). The CRD conclusions were that there were only two areas with robust evidence in support of recommendations in the NSF, one relating to CMHTs and the other to assertive outreach. We discuss both below. The CRD authors also noted that the evidence on care programming suggested that the approach was not effective, and again their conclusion accords with ours.

In relation to the NSF standards, there was insufficient review evidence on mental health promotion and on primary care interventions (standards 1, 2 and 3) to reach any conclusions. On standard 6 (caring about carers) there was little evidence in relation to carers of people with mental health problems. Finally, no systematic reviews related specifically to the alternative interventions to tackle the seventh NSF standard (preventing suicide).

Evaluative evidence – mental health promotion

The inclusion of a standard relating to mental health promotion in the National Service Framework was widely seen as ‘an important milestone’ (Friedli 2001). The *Effective Health Care Bulletin* looked at ‘mental health promotion in high risk groups’ in 1997. Although the evidence is now a little old, the review is useful in identifying the studies that have looked at preventive strategies in the mental health field. Much of the evidence relates to children, and so we do not discuss it in this chapter, and many of the studies that look at mental health promotion for adults have been conducted outside the UK. One UK study looked at group CBT and its impact on general mental health (Proudfoot et al 1997). Subjects in the study were people who were long-term unemployed. General mental health was improved, possibly because of the success in re-employment.

Some other studies have looked at depression in pregnancy, suggesting that ‘various forms of home support or home visiting during pregnancy improve mental well being of mothers and their children.’ There is a regularly updated Cochrane library review of studies in this area. However, the *Effective Health Care Bulletin* suggests that ‘interventions specifically designed to prevent post natal depression have ... shown contradictory results’, making it difficult to reach any clear conclusion.

Carer initiatives

The same issue of the *Effective Health Care Bulletin* looked at interventions to support people who are long-term carers of people who are highly dependent. These could be seen to be mental health promotion initiatives. We have discussed this evidence base in chapter 4, although the people being supported in some of these studies are not only older people.

Community intervention perspectives

Under the heading of mental health promotion it is interesting to look at a recent US paper by Wells et al (2004). They argue for more attention to be paid to what they call community intervention perspectives ‘that focus on behavioural change of the public or the development of communities and social action targets based on community priorities not necessarily involving health care change’ (p.960). These include public health and community development interventions, to be contrasted with practice-based interventions. Arguably, mental health policy in England, Wales, and Northern Ireland has moved (slowly) in the last few years away from being concerned almost exclusively

with practice-based treatments to tackle symptoms towards a more holistic, preventative, participatory approach aimed at promoting positive mental health.

As Wells and colleagues point out, such community interventions pose numerous design, implementation and evaluation challenges. In particular, RCT research designs are almost certainly impossible, which means that narrowly conceived reviews with tightly drawn inclusion criteria could miss such studies. Community intervention approaches also make it easier to employ a socially constructed model of mental disorder, whereas practice-based interventions and the robust research designs that they require or encourage will (or at least, *do*) tend to reinforce the medical model.

Evaluative evidence – hospital closure

There are two specific aspects of the hospital/community balance where evidence has come together in sufficient quantity and quality to allow conclusions to be drawn:

- community provision for former long-stay hospital residents (linked to studies of hospital closure), and
- intensive community support (such as assertive outreach) for people with acute illnesses who would otherwise face hospitalisation.

We focus first on the so-called ‘decanting’ studies, looking at hospital closure in particular. We then turn to the ‘diversion’ studies, which predominantly means looking at innovative service and team arrangements in community settings. In evaluating such arrangements probably the most common indicator of ‘success’ is avoidance of (symptomatic) relapse and/or the avoidance of inpatient admission (and in most mental health systems today a relapse for someone with a severe mental illness almost always means admission to inpatient care), although our earlier identification of a wider range of pertinent outcome dimensions means that we must look more broadly.

Hospital rundown; community ‘reprovision’

The changing hospital-community balance has obviously been one of the major themes of recent times and in large part has been achieved by relocating long-stay inpatients to suitably staffed community facilities. It is perhaps hard to remember how strong was the opposition to psychiatric hospital closures in some quarters. The controversy has abated considerably since the 1980s, although (as noted in Section 5.5) concern

continued for longer regarding the practical difficulties of building or converting care facilities in the community. One challenge for any review of evidence in this field has been the tendency for hospital closure programmes to move the most independent, least symptomatic people first (Renshaw et al 1988; Jones 1993), requiring adjustments to be made to outcome and cost findings before generalisations are possible (Knapp 1996). Another challenge is that randomised controlled trials have not been considered feasible in this area.

Longitudinal studies have been completed of service user (patient) outcomes and resource consequences of shifting long-term care to the community (Knapp et al 1992; Donnelly et al 1994; Leff et al 1996; Leff 1997; Beecham et al. 1997; Knapp et al., 1997). In most cases social care services would have been involved in community support. While it will be possible to identify the costs falling to social care agencies, it is usually impossible to disentangle the outcome or cost-effectiveness contributions of social care services within complex care packages. The establishment of multidisciplinary CMHTs makes this especially difficult and – referring back to Robbins' remarks quoted at the start of the chapter – increasingly inappropriate.

Studies of the rehabilitation of long-stay inpatients in the UK have found community-based care to be more cost-effective than hospital care for most people. This result applies particularly to those with less severe mental illness or fewer dependencies (Knapp et al 1995). However, many long-stay inpatients with very challenging needs are more costly to accommodate in the current range of community settings than in hospital, even though their clinical and social outcomes do show improvements. Success depends on having sufficient staffing intensity (Trieman and Leff 1996); that is, it depends on expending sufficient costs (Hallem and Trieman 2001; McCrone et al 2004).

The most comprehensive evaluation of community-based care for former long-stay inpatients looked at the closure of two North London hospitals, as we described in section 5.5. The outcome findings suggest that former inpatients were enjoying a quality of life at least as good as in hospital one and five years after discharge (initially this was by comparison with matched controls in hospital, but later became a mirror-image design). There were no problems with higher-than-normal mortality, or with homelessness and crime. Accommodation stability in the community was impressive, and care environments (as rated by researchers and residents) were much better than in hospital. Social networks were stable: a minority of people gained in this respect, but most were not socially integrated into local communities. Hospital readmissions were common (38 per cent had at least one readmission over a five-year period). Careful examination of clinical outcomes revealed striking stability over time in both psychiatric symptoms and social behaviour. Patients strongly preferred community living to hospital (Leff et al 1997; Leff 1996).

The associated economic evaluation found that many services were used in the community, with patterns of service use changing over time. The full costs were no different between community and long-stay hospital care (Beecham et al 1997). Pooling the cost and outcome findings suggested that community care was more cost-effective. Higher cost community care packages appeared to be associated with better individual outcomes. Care appeared to be more cost-effective in the public than in the private sector (see below).

The longest running study in this area is the twelve-year follow up of people who moved from long-stay hospital residence to a community setting under the auspices of the government's Care in the Community demonstration programme, launched in the 1980s (Renshaw et al 1988; Knapp et al 1992; Carpenter et al 2004; Beecham et al 2004; Cambridge et al 2003). At the twelve-year follow-up point, the former long-stay hospital inpatients were living in a range of settings: 39 per cent in residential or nursing homes, 17 per cent in less intensively staffed group homes or small hostels, 34 per cent in minimum (formal) support settings such as adult foster placements, unstaffed group homes, sheltered housing and independent domestic housing, and the remaining 9 per cent were permanently resident in psychiatric wards. Over the period, a number of abilities had declined (mobility, ability to wash, bathe and dress, and general appearance), but conversation and social interaction had improved. Ratings of co-operative behaviour had decreased. There were marginally significant increases in the reported incidence of odd gestures and mannerisms, obsessive behaviour, depression and suicidal preoccupation. There was also a marginally significant increase in the proportion of residents showing a degree of confusion. Nevertheless, the majority of people in the sample were functioning quite well and had relatively few symptoms and behavioural problems.

A much higher proportion of users were satisfied with their community accommodation than with hospital, and very few wished to return. There were substantial minorities who were not happy with the degree of privacy and choice offered and only half had positive relationships with neighbours. Relationships with staff were generally positive, but there was room for improvement. Many users in residential and nursing homes did not feel that they had choices in their lives. One-third of residents did not know who to complain to.

The average size of social networks (23 contacts) compared favourably to that reported in other studies. However, networks were mainly staff and other service users. Despite having lived in the community for over a decade, people were still interacting in a community within a community. Residents living in hospital or hostels and small group homes had fewer close and confiding relationships compared to those in other accommodation types. Residents in hostels and small group homes were least frequently in contact with their network members. Residents living in private and

voluntary sector accommodation received less help with domestic tasks, less material aid and less support for decision making compared to people living in accommodation managed by the public sector. They also had fewer confiding relationships. Conversely, they were less likely to be on the receiving end of critical behaviour from their network members.

Many organisations were involved in supporting service users in the community (Beecham et al 2004). There was, however, little evidence to suggest that organisations were working together to create support packages that crossed traditional agency boundaries – reinforcing what others have found (as discussed earlier in the section on targeting). For example, people with mental health problems living in social services managed accommodation rarely used services provided by the NHS Trusts. The average weekly total cost per resident remained lower than the long-stay hospital costs. However, the range was considerably wider, suggesting a greater diversity of support arrangements. After standardising for users' skills and behaviour problems, costs in supported accommodation were significantly lower than expected and costs for people living permanently in hospital were somewhat higher than expected. The support costs could not be predicted from the characteristics of users as measured in hospital twelve years earlier. There was no evidence of a relationship between cost and changes in skills, but there was some evidence that the more a person's behaviour had deteriorated over the twelve-year period, the more costly was their package of care.

Differences between provider sectors

We have already described findings from the closely evaluated closure programme for Friern and Claybury hospitals. Further analyses looked at quality of care, outcome and costs in hospital and 12 months after discharge by provider sector. For the purposes of those analyses, attention was restricted to the 429 people living in specialist mental health accommodation in the community; i.e. people in independent accommodation, hospital and community inpatient units were excluded (Knapp et al, 1999). As we saw in section 5.5, the voluntary and private sectors were important providers for this group of people, as indeed were the NHS and local authority social services departments.

The different sectors were not accommodating people with identical needs or dependency profiles, but these differences did not appear to account for inter-sectoral variations in costs. Even after adjusting for the effects of resident characteristics, the costs of community care were lower in the private sector than elsewhere, and higher in the NHS and consortium (NHS and voluntary sector in partnership) sectors. Costs in the private sector were almost half the costs in all other sectors, partly because the residential accommodation itself was less costly and partly because people in private facilities used fewer services outside their place of residence. But it is possibly a third

reason for the lower costs which is the most relevant. In the smaller homes run by owner-managers (in some cases former nursing staff from the hospitals who knew the residents before they moved to the community) the fees paid by public sector purchasers or by the DSS may not have covered the full costs of residence. Certainly these fee levels were seen as a constraint by many proprietors, and the impression gained during interviews was that some owner-managers were operating at a recurrent loss. The lower costs in the private sector may have been achieved at the expense of lower quality care, for there was strong evidence of fewer opportunities for residents and more environmental restrictions in private facilities which could not be put down to chance. The NHS and NHS/voluntary sector consortium facilities performed significantly better than other sectors by these criteria, although these were easily the most expensive facilities. Whether these quality of care differences worked through to generate differences in user outcomes is not so clear, however, for there were comparatively few changes in health or quality of life during the first year of community residence. What changes there were confirmed what Leff et al. (1996) previously concluded from their evaluation for the wider sample of former hospital residents: community-based care is superior to continuing hospital care. But one year is rather a short period over which to judge outcomes for people with long-term mental health problems who have spent substantial proportions of their lives in sheltered hospital environments. The lower-cost sectors may be achieving fewer or poorer outcomes for users, but we would really need to study the impact over a longer period to be sure.

A similar conclusion was reached from a study of nearly 2000 residents of local authority, voluntary and private specialist community mental health accommodation in eight areas of England and Wales (Knapp et al., 1998b; see also Chisholm et al 1997). In London, voluntary sector facilities appeared to be more cost-efficient, whereas outside London both the voluntary and private sectors had cost advantages over local authority provision. This previous study of inter-sectoral comparisons was able to look at a larger sample of users and facilities than the reprovision study reported here, and to draw the sample from a broader spread of localities, but it had few data on quality of care and was not longitudinal, so had no data on user outcomes.

The twelve-year follow-up of the Care in the Community demonstration programme sample found no differences in costs between managing agencies (after adjustment for individual characteristics) (Beecham et al 2004).

Evaluative evidence – short-stay admissions

Johnstone and Zolese (2004; last updated February 1999) looked systematically at the evidence on the effects of planned short stay admission policies compared to standard stay services for people with mental health problems. Only randomised trials were

reviewed, and five were found to meet their inclusion criteria. The evidence was not particularly strong, and in particular there was little or no data on user satisfaction, mortality, violence, criminal behaviour or costs. The conclusions from the review were that 'that a planned short-stay policy does not encourage a "revolving door" pattern of admission and disjointed care for people with serious mental illness'. However, they warn that the quality of the evidence that they uncovered was not strong.

Evaluative evidence – community care arrangements

We will not labour again the difficulties of sorting the models of practice and the evaluative evidence into well-defined categories when it comes to the discussion of community-based service and team arrangements. As we indicated earlier, we shall first pool the evidence under the general heading of 'home treatment', before looking at some specific arrangements where it makes sense to do so.

Home treatment

A large number of models of intensive, community-based care have been developed and implemented across the world, all with the intention of supporting people with acute and chronic mental health problems outside inpatient settings if at all possible, but facilitating hospital admissions when they are needed. Many rely on social care inputs to multidisciplinary teams and service packages. This wide range of models has been given an equally wide range of names (but not consistently), and with a great deal of variance from the original (and usually evidence-based) models of care. For these reasons, the systematic review by Burns et al (2001) grouped all services aiming to treat patients outside the hospital under the single heading of 'home treatment', arguing that 'the lack of a clear definition of different community-based models undermines any attempt to evaluate specific services through meta-analysis' (Catty et al 2002 p.384). Each of the previous reviews in the area was criticised for taking study authors' labels for the interventions as sufficient to allocate a service or arrangement to a category.

The previous systematic reviews in this area were carried out for:

- case management, defined as including 'care' or 'case management' or 'care programme approach' (CPA), excluding ACT (Marshall et al 1998). This review found case management ineffective;
- assertive community treatment (ACT), but not looking at ACT as an alternative to hospitalisation (Marshall and Lockwood 1998), finding positive evidence in support of this approach

- community mental health team (CMHT) arrangements (Tyrer et al 1998). This review concluded that CMHTs might just be superior to standard care in reducing inpatient admissions; and
- crisis intervention studies, rather loosely defined compared to what would be interpreted as crisis intervention in today's mental health systems (Joy et al 1998). The intervention was found to be 'viable and acceptable'.

Other complications arise when trying to interpret the evidence reviews:

The short duration of some studies and close links between experimental services and academic departments (Tyrer et al 1998) may limit the generalisability of findings and their translation into routine practice. Moreover, recent studies of home treatment tend not to match the reductions found earlier (Stein and Test 1980; Holloway et al 1995), arguably due to an improvement in 'standard' services (Burns et al 1999). The confusion this generates in terms of robust research is compounded by the fact that services from different years may contain different components, even if given the same label. The ubiquitous labels 'standard care' and 'usual services' for control services are also commonly ill-defined. These factors pose problems in interpreting research findings (Catty et al 2002 pp.383-384).

To complicate matters further, evidence from North America (where most of it comes from) is significantly different from evidence from the UK: the North American studies find greater differences between experimental and standard services in terms of days in hospital (Burns et al 2002).

The new review therefore looked at the 'home treatment', defined as 'any service aiming to treat the patient outside hospital as far as possible and enabling them to stay in their usual place of residence'. Studies of day care, foster care and residential services were excluded. The review found that 97 per cent of the experimental service had a 'home treatment function' and 95 per cent 'regularly visited (users) at home'. The services were fairly heterogeneous in terms of such components as percentage of visits made at home, caseload size and contact frequency.

In what follows in this subsection, we draw heavily on the Burns/Catty systematic review, on which we worked. Tables 5.1 and 5.2 are extracted from Catty et al (2002) and list only the UK studies uncovered by that review.

The outcome measure used in the meta-analysis was days spent in hospital over the follow-up period. Other outcomes were not analysed, and many of those used by researchers have been inadequately validated (Marshall et al 1997). Using days in

hospital during the follow-up period as a proxy for clinical outcome is obviously not ideal as it measures service use rather than service user outcome (Rössler et al 1992). Notwithstanding these difficulties, when compared with inpatient care as the control intervention, the review calculated that home treatment reduced hospital days by, on average, 3.3 days per service user per month (including RCTs and non-RCTs: the former generally find bigger differences). When compared with other community care arrangements, the experimental home treatment services reduced hospital days by 0.5 days per service user per month.

Turning to the service components some significant associations emerged from the analyses. Too few of the studies reviewed had inpatient services as the control intervention to allow the reviewers to test relevant service components. For community-control studies, two components were significantly associated with fewer days in hospital: 'regularly visiting patients at home' (reduced inpatient days by 0.6 days per person month) and 'responsibility for health and social care', (where only the experimental service took dual responsibility for health and social care the difference was 1.3 days per user per month).

The review found that two other service components had no impact on number of inpatient days: having a 'home treatment function' or the percentage of contacts at home. Too few studies tested a multidisciplinary against a non-multidisciplinary service. In the experimental (home treatment) arm, smaller caseloads were associated with more days in hospital: the opposite direction of effect of that predicted, although the difference was modest: an increase in caseload of 10 patients reduced hospitalisation by 0.7 days per patient per month.

Overall, therefore, Catty et al (2002, p.398) concluded:

There is some evidence that visiting patients at home and taking dual responsibility for health and social care may be associated with a reduction in hospitalisation. There is none, however, for other service components, and no evidence for a clinically meaningful superiority of 'home treatment' over other forms of community-based care.

In a study published after completion of the Burns/Catty review, Kuipers et al (2004) looked at one of the new emphases in mental health policy: an 'early intervention ACT' model for psychosis treatment. They found little evidence to support the early intervention model compared to usual treatment. The ACT team leader had a social work background, while other team members had qualifications in nursing, occupational therapy, clinical psychology, psychiatry and family therapy. Caseloads were small (less than 12 per care co-ordinator). There were no clinical or functioning advantages – both the ACT and treatment as usual groups improved – but carer quality of life was (not

significantly) higher and inpatient bed days (not significantly) lower. The small sample left the study under-powered to detect differences in bed days. Kuipers et al conclude that 'early outcomes for psychosis are reasonably promising, particularly for those who remain in contact with services' (p.362), and that it may not be advisable to target resources on particular client groups (cf Pelosi and Birchwood 2003).

Cost-effectiveness

What can be concluded with regard to cost-effectiveness?

The *assertive outreach* approach has been the most widely evaluated. A London modification of the ACT model - the Maudsley's Daily Living Programme (DLP), which for a short while included social work input – looked at seriously mentally ill people facing crisis admission to the Maudsley Hospital. A randomised controlled trial recruited 189 people with serious mental health problems. The DLP produced better outcomes, higher patient and family satisfaction and lower costs than standard care in the short term (Marks et al 1994; Knapp et al 1994), but after 4 years there were no differences in clinical or other outcomes, or in costs (Audini et al 1994; Knapp et al 1998a). Nevertheless, over the full 4-year period the DLP was more cost-effective than standard hospital-based care (inpatient followed by outpatient supervision). Other studies confirm the cost-effectiveness of community-based crisis interventions, which may be seen to have ACT-like characteristics, including one in the UK (Ford et al 2001). The overall weight of evidence is that forms of ACT that adhere more closely to the original Wisconsin model are more cost-effective than conventional hospital-based services or other community arrangements (Latimer 1999; National Collaborating Centre for Mental Health 2002). Research in the US has also begun to examine the patient characteristics associated with greater cost-effectiveness (Mueser et al 1998).

At least one study has found that a variant of *case management* (including intensive case management) is effective and cost effective (Muijen et al 1994; McCrone et al 1994), whilst others do not (Ford et al 1997). When comparing the cost-effectiveness of the standard and intensive forms of case management, two non-UK studies found the standard form to be more cost-effective. However, the UK700 study – a large randomised controlled trial – showed the two approaches to be equally cost-effective, and concluded that reduced caseloads have no clear beneficial effect beyond that achieved with standard case management (Byford et al 2000). There were significant quality of life improvements over a two-year period, but no differences between intensive and standard case management (Huxley et al 2001).

A London study compared CPAs administered by either community-based or hospital-based teams following discharge from inpatient care, finding higher costs for the latter

without any difference in outcomes (Tyrer et al 1997). However, the high use of placements in private hospitals in one locality confounded the findings. Other studies of community mental health teams give equivocal results (Gater et al 1997; Merson et al 1996; Burns and Raftery 1993).

An overall view?

Looking across the range of experiences, Tyrer (1998a) concluded that

The exact model of community care being offered, whether assertive, intensive or standard, is really unimportant. The key to the success lies in having a coordinated team approach to the care of the severely mentally ill in which each member has the requisite skills to intervene appropriately and at an opportune time to produce the maximum benefit. Supporting the team's skills is therefore more important than reducing the caseloads of individual workers. Our preoccupation with the bureaucracy of care - caseload size, care programme levels, independent needs assessment - has prevented us from examining the more difficult task of what makes a team function badly or well, or in another sense, what allows it to be effective and assertive even if relatively deprived of resources.

It is usually unclear what social care inputs are being provided to the care arrangements evaluated, and almost always impossible to know what are the 'active ingredients' in multidisciplinary interventions, if indeed it makes sense to talk in such terms. This was one of the difficulties reported by Burns et al (2000) in the UK700 trial that did not allow them to identify those elements of intensive case management that may have led to better outcomes (see also Arthur et al 2002).

Evaluative evidence - supported housing

The Cochrane review by Chilvers et al (2004; last updated July 2002) looked at the effects of supported housing schemes compared with outreach support schemes or standard care for people living in the community. They included not just RCTs but some other research designs. They concluded that 'dedicated schemes whereby people with severe mental illness are located within one site or building with assistance from professional workers have potential for great benefit as they provide a "safe haven" for people in need of stability and support.' However, there is a risk that service users grow dependent on professionals in a way that could prolong their exclusion from the community. They found little evidence on supported housing and recommended that research be undertaken in this field. No cost-effectiveness evidence is reported.

Evaluative evidence – employment

A small number of trials of pharmacotherapies and psychosocial interventions have included paid employment among the outcome indicators. (The study by Proudfoot et al 1997 was unusual in examining a treatment that was specifically targeted on re-employment.) Treatments that are successful in terms of symptom reduction might be expected to have beneficial effects on employment (at least on employment ability), although the connection is unlikely to be straightforward. We do not provide the details here, nor do we discuss workplace initiatives for people with common mental disorders who are already in paid employment. Both are important, but neither relates very immediately to social care responsibilities. (See Curran et al 2004 for reviews of both.) As we have just seen, some community care ‘arrangements’ such as assertive outreach can also help mental health service users find jobs.

In section 5.6 we discussed the different approaches taken to supporting people in employment, and noted today’s policy emphasis in England on ‘place and support’ models (IPS). Evaluations of programmes normally consider both *vocational* and *non-vocational outcomes*. The former category includes competitive employment (defined as a job paid at the market rate for which anyone can apply), time in paid employment (full or part-time, competitive or sheltered), and total job earnings. Non-vocational outcomes include therapeutic measures (such as treatment compliance or symptom reduction), functional status in other areas (activities of daily living, maintenance of living situation, etc.), self-esteem, and subjective quality of life.

There is good evaluative evidence on some employment-related interventions although very little comes from studies carried out in the UK (although we are aware of a number of UK studies now underway). Crowther et al (2001) conducted a systematic review of approaches to help people with severe mental illness to obtain work. The review drew on eleven trials dating from 1963 in a three-way comparison of pre-vocational training, supported employment and standard community care. All the studies were from the US. Of the three interventions, supported employment programmes appeared to generate the best outcomes in terms of the number of people gaining competitive employment. Although the primary outcome measure in these trials was rate of entry to competitive employment, three studies (all from the US) showed that people in supported employment worked more hours than those who received pre-vocational training (Drake et al 1996, 1999, Gervy and Bedell 1994). Three showed higher monthly earnings (Bond 1995; Drake et al 1996; McFarlane et al 2000). Given the links between employment and mental health it is perhaps surprising that the two studies reporting mental health-related outcomes found no differences in self-esteem, quality of life or severity of symptoms for people receiving supported employment or pre-vocational training (Drake et al 1996, 1999).

Latimer (2001) reviewed (from a Canadian perspective, although his conclusions look broadly generalisable) the economic impacts of supported employment compared with a range of control interventions – from day treatment with little vocational rehabilitation to ‘state of the art’ stepwise programmes. All studies reviewed were set in the US. His main conclusions were that converting day treatment or other less effective vocational programmes to supported employment can be cost-saving or cost neutral from the points of view of the hospital, community and government. The costs of introducing supported employment schemes are modest, but the schemes need to substitute for existing services to ensure that they are at least cost-neutral. Investments of *new* money in supported employment programmes are unlikely to be materially offset by reductions in other health care costs, reductions in government benefit payments or increased tax revenues. Such investments would therefore need to be motivated by the value of increasing the community integration of people with severe mental health problems.

A project in South West London reported good vocational outcomes for a programme that helps people with mental health problems gain and retain employment, initially through jobs with an NHS trust. Positive vocational outcomes are described by Perkins et al (2002), who estimated a net gain of £1900 per person participating in the programme, through a reduction in benefits paid and taxes collected. Moreover, ‘not only has the programme been successful in supporting people in employment, but also that these supported employees have more positive attitudes towards people with mental health problems and take less time off sick than non-disabled members of the direct care workforce of the Trust’.

Evaluative evidence – day hospitals

Marshall et al (2004; last updated February 2001) reviewed day hospital as compared to out-patient care for the Cochrane Collaboration. Three types of day hospital were covered: day treatment programmes, day care centres and transitional day hospitals. Only randomised controlled trials were included, and the focus was confined to working age adults.

There was evidence from one trial suggesting that day treatment programmes were superior to continuing outpatient care in terms of improving psychiatric symptoms. There was no evidence that day treatment programmes were better or worse than outpatient care on any other clinical or social outcome variable, or on costs. There was no evidence that day care centres were better or worse than outpatient care on any clinical or social outcome variable. There were some inconclusive data on costs suggesting that day care centres might be more expensive than outpatient care. There was evidence from one trial suggesting that transitional day hospital care was superior

to out-patient care in keeping patients engaged in treatment, however, there was insufficient evidence to judge whether it was better or worse on any other clinical or social outcome variable, or on costs. ... There is only limited evidence to justify the provision of day treatment programmes and transitional day hospital care, and no evidence to support the provision of day care centres.

Evaluative evidence – non-medical day care

The Cochrane Review of day centres by Catty et al (2004; last updated January 2001) focuses on non-medical day centre care, in contrast to the Marshall et al (2004) review of what appear to be more health-oriented programmes. Catty et al confine themselves to RCTs. Unfortunately, no trials were found of non-medical day centres, despite over 300 citations being identified by the electronic search. The reviewers argued that 'the inclusion of any studies less rigorous than randomised trials would result in misleading findings and that it is not unreasonable to expect well designed, conducted and reported randomised controlled trials of day centre care'. They also comment that non-randomised studies 'give conflicting messages about the roles provided by day centres and the clinical and social needs they are able to meet'.

Evaluative evidence – life skills programmes

Robertson et al (2004; last updated May 1998) carried out a Cochrane review of life skills programmes for people with chronic mental health problems. These programmes address needs associated with independent functioning, and are often delivered as part of a rehabilitation process. Randomised and quasi-randomised controlled trials were reviewed, but only two were found to meet inclusion criteria, and no clear effects were demonstrated.

Choice and user involvement

Choice dominates today's discussions of health policy (e.g. Secretary of State for Health 2004). In chapter 4 we found it helpful to review evidence on choice by distinguishing four dimensions: diversity of services, information on those services and what they could do for service users, empowerment of service users in the decision-making process, and complete control in the choice (and indeed purchase) of services. The last of these elements is particularly associated with direct payments, which as we have seen have begun to be offered to and taken up by adults with mental health problems, albeit very slowly. The last of these, control, also describes the situation when service users make out-of-pocket purchases of their own treatments or services. For most people, however, self-funded services are not an option. People with long-term, often very disabling mental health problems find themselves socially excluded, and certainly not with the financial means to be purchasing their own treatments. Nor would we expect them to do so given our universal, tax-funded health system in the UK.

Subsequent to the completion of that chapter we have read Barnes' (1997) book which sets out a similar set of steps: there need to be service alternatives, information on them needs to be accessible to service users, moving from one option to another must be possible, and moving from one option to another should not in itself be harmfully disruptive. The last of these opens up some interesting questions about the domain over which individuals should be allowed freedom of choice and action. User involvement, empowerment and choice have of course received increasing attention from policy, practice and research.

It is probably fair to say that the discussions of user choice in policy documents of the early 1990s rarely got to this level of detail: there was almost an implicit assumption that promoting service diversity and encouraging care managers to consult service users would be sufficient to establish choice in the mental health system. User involvement and choice (consumerism) are not one and the same, and until recently attention has been mainly focused on the former. Even then, there has been 'considerable confusion about the meaning and purpose of user involvement and about how service users can best be represented' in relation to the planning and management of services' (Bowl 1999 p.165).

Recent policy announcements and practice guidance documents set out more detailed plans and recommendations for a more inclusive strategy. The Department of Health (2001g), for example, argued that: 'Improved information will support service user empowerment and improved safer care' (p.22). A NIMHE (2003b) booklet identified five arguments for involving service users and the general public in decision making: accountability, developing local understanding, strengthening public confidence,

encouraging services to become more responsive, and challenging any paternalistic models of provision. User involvement brings a particular expertise and a different perspective to the decision making forum, can be therapeutic, and can help new approaches to meeting needs to emerge.

A review by NIMHE (2003h) traces service user involvement since the 1980s, identifying some of the main barriers, influences and successes. Service user involvement in planning and monitoring of services was 'fairly promising' according to the SSI (Robbins 2004, p.15), with 60 per cent of local implementation teams 'meaningfully involving some service users in the planning and monitoring of services', and the remaining 40 per cent having 'effective structures and systems for ensuring that a wide network of service users is involved in the planning and monitoring of services'. In relation to user-led services, 76 per cent of LITs were rated as 'working to establish or increase the provision of user-run or led services within the LIT area', and 17 per cent had 'user-run or led services ... provided at a level that the LIT deems to reflect an adequate mix within the overall provider arrangements'.

Progress is indeed therefore promising, but there is still some distance to go in ensuring that all service users have the opportunity to be involved in service planning and decision-making if they wish. CHI (2003), for example, found that systems for involving service users were often absent or ineffective. Langan and Lindow (2004) found low levels of involvement of service users considered by staff to pose a potential risk to other people. NIMHE (2003h p.4) expressed concern that 'the often very good intentions of service providers can sometimes fail to move beyond the rhetoric into reality'. Among the barriers are lack of information for service users, the time and money costs of user involvement, concerns about 'representativeness', and the experience of some users that involvement can be disempowering. For more detail on these and other issues concerning user involvement in mental health services see Barnes (1997), NIMHE (2003h) and Sainsbury Centre for Mental Health (2003b).

The SSI conclusion was that:

The active involvement of service users in their own care planning was too often very limited, with insufficient focus given to the need – and potential – for people to participate in socially inclusive activities. Greater transparency around care planning, with better sharing of information at all stages would help here (Robbins 2004 p.16).

Promoting user empowerment is necessary but not sufficient for promoting user choice. Another key ingredient is diversity, in particular responding through service provision to the diversity of needs and preferences of service users. One particular emphasis throughout the recent policy literature, and identified as a failing by many reports and

studies, is the provision of culturally sensitive services. The Department of Health (1999f) concluded that

Local health and social care communities, when planning and providing services, should ensure that carers from black and minority ethnic communities have access to the information which they need; are able to use culturally appropriate services; and can contribute to service planning and development.

We have already discussed the poor targeting of services and support on the needs of BME service users. Robbins (2004) reports that two-thirds of local authorities are not yet sure whether their Race Equality Schemes will directly result in service improvements. She goes on to recommend that information should be improved, including information about who and where are the service users from black and ethnic minority communities, their needs and their wants. Progress in this regard was described as 'disappointing' (Robbins 2004). There was a particular problem with slippage in the development of 'plans for improving the provision of services which would be accessible to black and ethnic minority service users' (p.19). A publication by NIMHE (2003), *Inside Outside*, had proved helpful to some authorities. Robbins urges that the development of culturally appropriate and accessible services for local BME groups should be 'a high priority' (p.20).

Appendix to chapter 5

The NSF (Department of Health 1999f pp.124-126) set out recommendations for outcome indicators for severe mental illness.

Indicator related to reduction or avoidance or risk of severe mental illness

1. Prevalence of severe mental illness.

Indicator related to detection of severe mental illness early

2. Inpatient admission on detection of severe mental illness.

Indicators related to maintenance of function and reduction of need for hospital admission

3. HoNOS scores for a service provider population of people with severe mental illness.
4. Proportion of people with severe mental illness lost to follow-up by specialist services.
5. Proportion of people with severe mental illness discharged from follow-up by specialist services.
6. Proportion of people with severe mental illness spending more than 90 days in a given year in inpatient psychiatric care.

Indicators related to restoration of function and reduction of relapse following hospital admission

7. Longitudinal indicators of change in item, subscale and total HoNOS scores among people with severe mental illness admitted to inpatient psychiatric care
8. Hospital re-admission frequencies for a resident population of people with severe mental illness

Indicators related to promotion of independent living and well-being

9. Service user-assessed health-related quality of life for a service-provider population of people with severe mental illness.
10. Prevalence of side-effects associated with maintenance neuroleptics within a service provider population of people with SMI
11. Paid employment status of people with severe mental illness
12. Financial status of people with severe mental illness
13. Accommodation status of people with severe mental illness

Indicators related to sustaining a collaborative approach

14. Summary of a measure of service user satisfaction with respect to a specific mental health service among people with severe mental illness
15. Percentage of CPA care plans for people with severe mental illness signed by the service users

Indicators related to supporting carers

16. Assessment of impact of severe mental illness on carers.
17. Mortality among people with severe mental illness.
18. Use of non-psychiatric health care services by people with severe mental illness

Indicators related to ensuring protection of carers, service providers and the public

19. Number of homicides by people with severe mental illness.

20. Incidence of serious physical injury resulting from assaults on staff and service users by people with severe mental illness.

Table 5.1 Randomised controlled trials of home treatment: one reference only is given per study* (The predominant diagnostic profile of the subjects was 'psychotic' unless stated otherwise)

Study reference	Control service			Experimental service			N [†]
	Location	First	Second	Type	Label	Special patient group	
Ford et al 1997	London, UK	ICM	N/A	Community	Standard care	HSU	77
Gater et al 1997	Manchester, UK	CMHT	N/A	Inpatient	Inpatient	No	108
Gournay & Brooking 1994 [‡]	Middlesex, UK	CPN	Waiting list then CPN	Community	GP	No	177
Holloway & Carson 1998	London, UK	ICM/ACM	N/A	Community	CPN Service	No	70
Marshall et al 1995	Oxford, UK	Social Services CM	N/A	Community	Standard care	Homeless	80
Muijen et al 1992	London, UK	Home-based care	N/A	Inpatient	Inpatient	No	189
Muijen et al 1994	London, UK	CPN teams	N/A	Community	Generic teams	HSU	82
Paykel et al 1982 [‡]	London, UK	CPN	N/A	Community	Out-patient	No	122

Sellwood et al 1999	Manchester, UK	Home-based rehabilitation	N/A	Community	Out-patient	No	75
Tyrer et al 1995	London, UK	Close supervision	N/A	Community	Standard care	No	400
Tyrer et al 1998	London, UK	Multi-disciplinary CMHT	N/A	Community	Out-patient	HSU	155

* For full reference list see Burns et al 2001.

† Total number of subjects in the study (-, indicates data missing).

‡ Predominant diagnostic profile of subjects was 'neurotic'.

Abbreviations: ACM, Assertive case management; ACT, assertive community treatment; CM, case management; CMHC, community mental health centre; CMHT, community mental health team; CPN, community psychiatric nurse; DD, dual diagnosis with substance misuse; HSU, high service users; ICM, intensive case management; ISA, integrated service agency; N/A, not applicable; NK, not known, OT, occupational therapy; PACT, programme for assertive community treatment; TCL, training in community living.

Table 5.2 Non-randomised studies of home treatment: one reference only is given per study* (the predominant diagnostic profile of the subjects was 'psychotic' unless stated otherwise)

Study reference	Location	Control service			Experimental service			N [†]
		Study type	First	Second	Type	Label	Special patient group	
Dean and Gadd 1990	Birmingham, UK	Retrospective	Home	N/A	Inpatient	Inpatient	No	99
Dean et al 1993	Birmingham, UK	Prospective	Home	N/A	Inpatient	Inpatient	No	124
Ford et al 1996	London, UK	Prospective	ICM	N/A	Community	Standard care	No	94
Grad (Sainsbury and Grad) 1966	Chichester, UK	Prospective	Community care	N/A	Inpatient	Inpatient	No	1416
Melzer et al 1991	London, UK	Prospective	CMHC	N/A	Community	Standard care	No	140
PRISM 1998	London, UK	Prospective	Intensive (PACT)	N/A	Community	Generic team	No	302
Tyrer et al 1984 [‡]	London, UK	Prospective	GP psychiatric clinics	N/A	Community	Out-patient	No	-

* For full reference list see Burns et al 2001.

† Total number of subjects in the study (-, indicates data missing).

‡ Predominant diagnostic profile of subjects was 'neurotic'.

Abbreviations: ACM, Assertive case management; ACT, assertive community treatment; CM, case management; CMHC, community mental health centre; CMHT, community mental health team; CPN, community psychiatric nurse; DD, dual diagnosis with substance misuse; HSU, high service users; ICM, intensive case management; ISA, integrated service agency; N/A, not applicable; NK, not known, OT, occupational therapy; PACT, programme for assertive community treatment; TCL, training in community living.