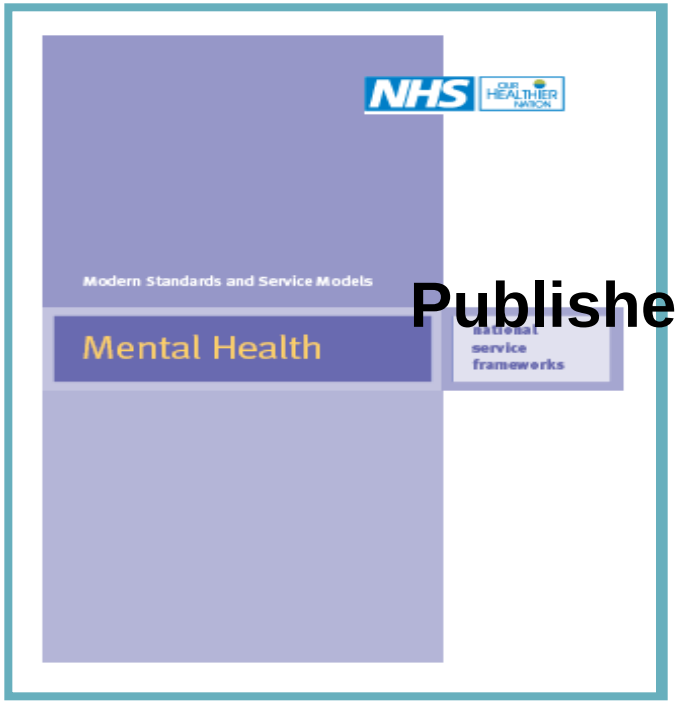
Sustainability of English mental health services: past, present and future

Peter Ryan
Professor of Mental Health
XVIIe COLLOQUE DE L'AQRP
Montreal November 12th-14th November
Quebec

Focus of Presentation

- **Part 1:** 1997-2005: The past: the National Service Framework in context
- **Part 2:** 2005-2014 Sustainability: living with the reality of cuts
- **Part 3:** 2014 - The future: towards co-production

The NSF

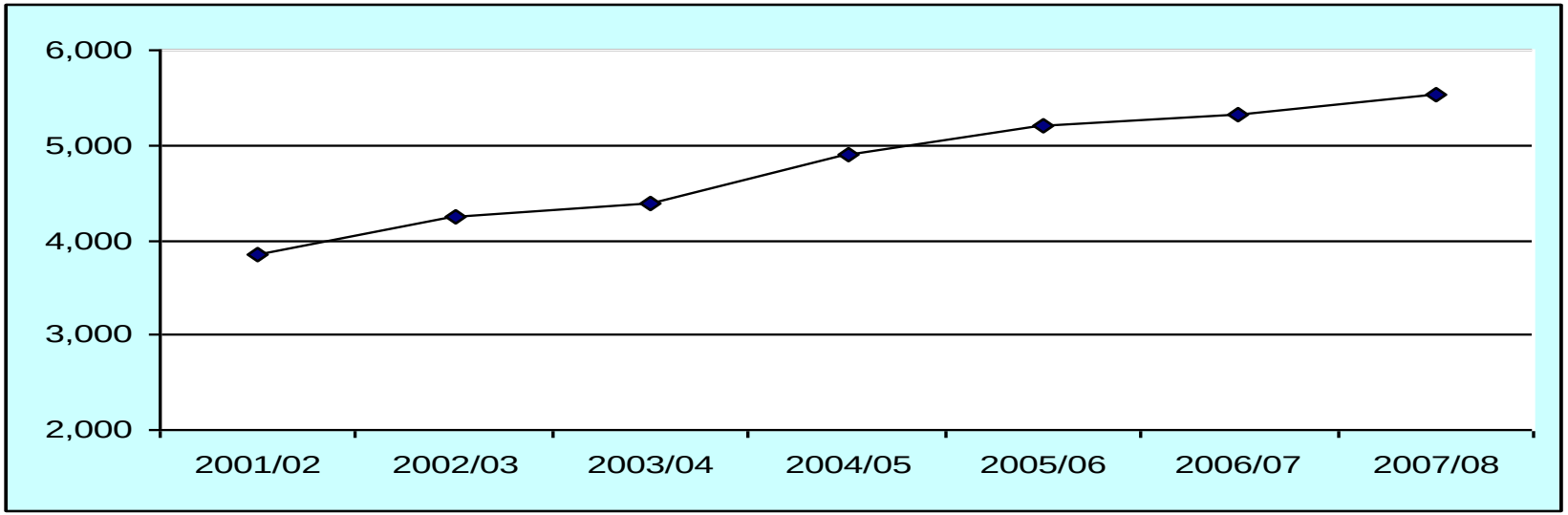


Published 1999

NHS Plan Targets (1998 -2005)

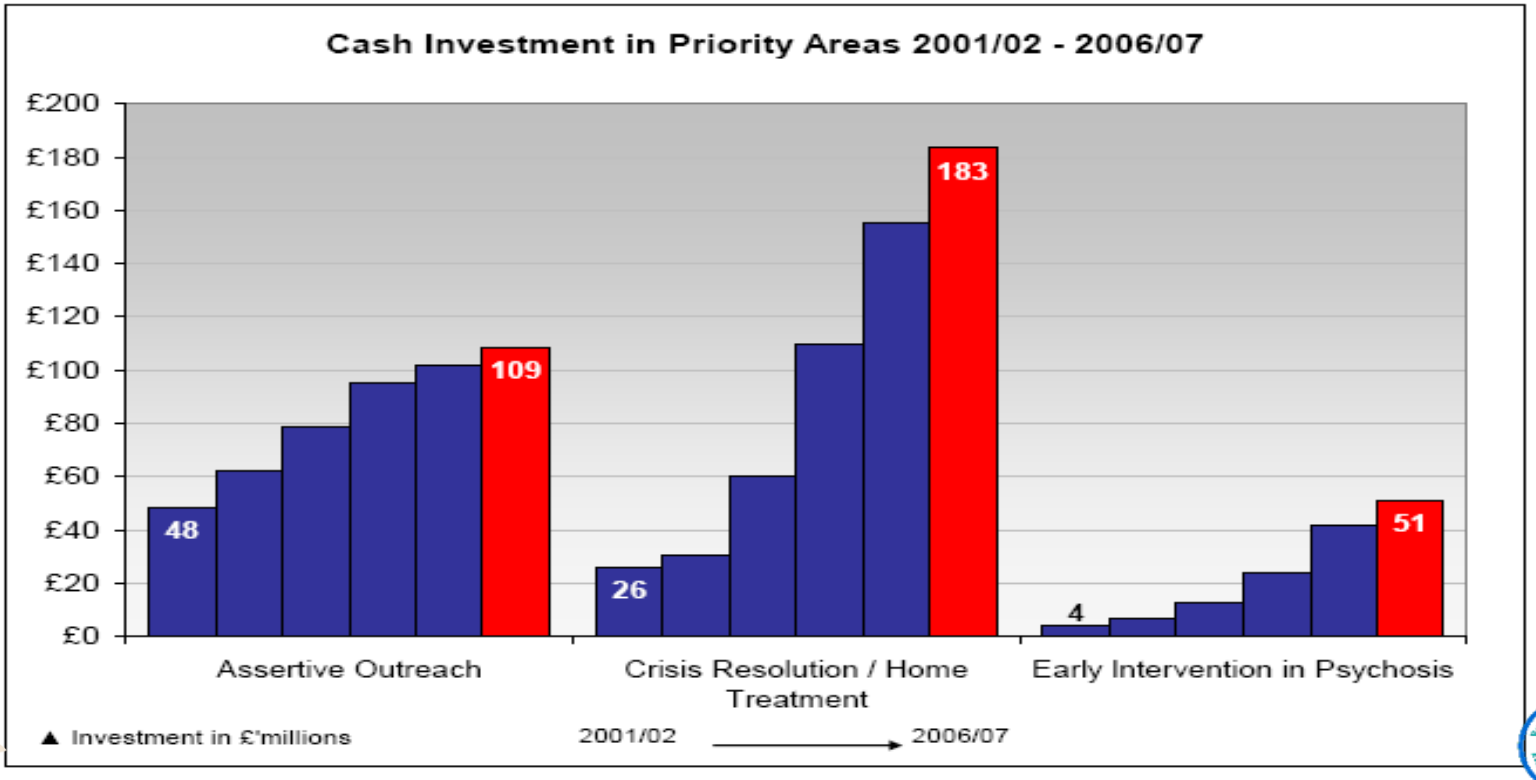
- **220 Assertive Outreach Teams**
- **335 Crisis Resolution/Home Treatment Teams**
- **50 Early Intervention Teams**
- (development of necessary workforce)

Investment in mental health services for adults (£millions)

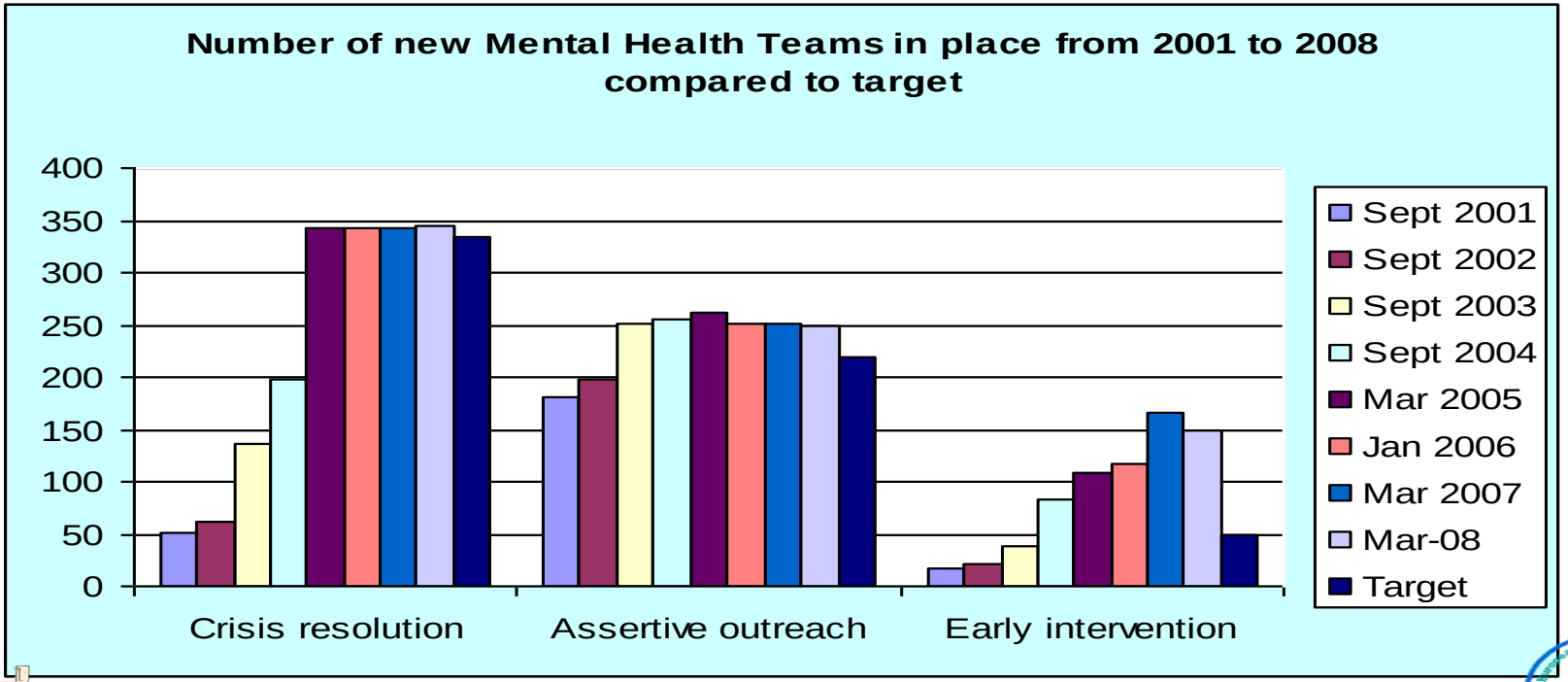


Source: Mental Health Strategies

NSF Investment

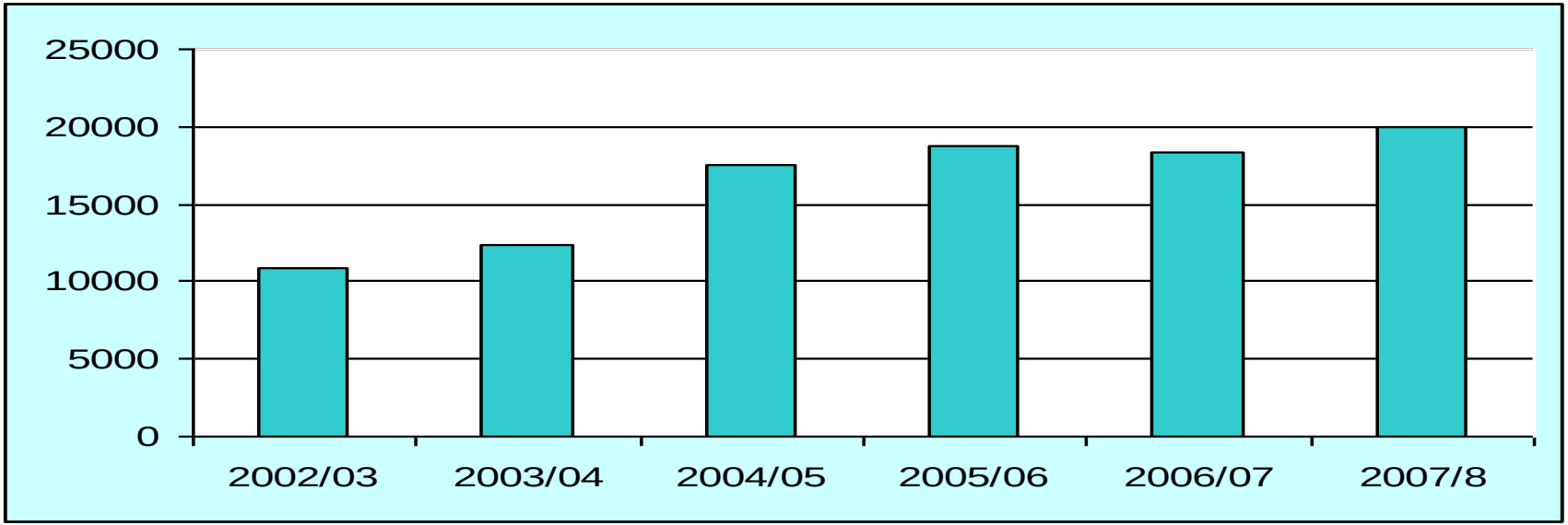


New mental health Teams



Source: Service Mapping exercise

People served by assertive outreach teams



Source: Local Delivery Plan return

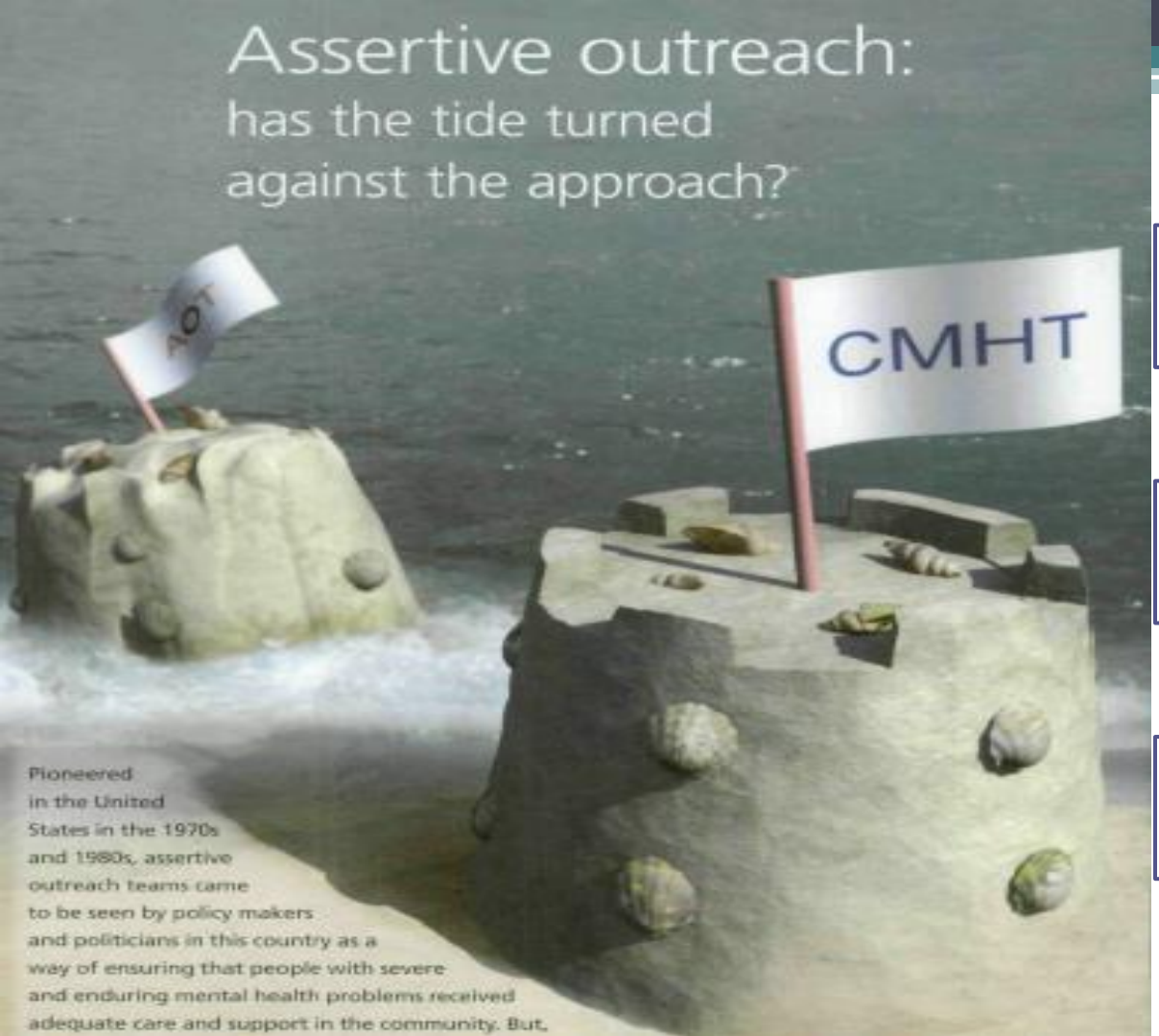
Part 2: 2005-2014 Sustainability?

The context

- The financial melt-down
- Real service cuts in mental health since 2006 – drift towards ‘rationalising’ the NSF service model
- Social Consequences - mental health, unemployment, alcohol and drugs misuse (Audit commission, 2009)
- A national mental health strategic direction hiatus

The Cuts: 2010-2013

- A freedom of information request by BBC: more than two-thirds of mental health trusts are reporting a total drop in real-term spending of 2.3 per cent since 2011/12, and ten trusts are projecting further cuts next year.
- Responses to Community Care Freedom of Information request from 51 NHS mental health trusts found that budgets for crisis teams has fallen by 1.7 per cent in real terms compared to 2011/12. At the same time, referrals to these teams have increased, on average, by 16 per cent



Optimism / Faith

Doubt / Denial

Confirmation

ACT = Case Management

- Designed for (in UK) : people with long term severe mental illness with complex health and social care needs and who in addition cannot be engaged by other service modilities
- Goals of case management
  - Easy access to needed service and coordinate care of clients.
  - Prevent avoidable episode of illness
  - Control or reduce the cost of care
- Activities of case management-
- Identification, assessment, service planning, monitor, service delivery, advocacy

ACT = Collaborative Care

- Definition-It is the shared planning, decision making, goal setting and assumption of responsibilities by individuals who work together cooperatively and with open communication
- Key features
  - Close collaboration of mental health key workers with all other health and social are provided needed to realise the care plan
  - Addressing the needs of the whole family
  - Multi-disciplinary collaboration

The REACT study: randomised evaluation of assertive community treatment in north London

Helen Killaspy, Paul Bebbington, et al BMJ APR 2006

- No ⇓ in bed use
- No ⇓ in cost or ⇑ in cost effectiveness
- No ⇑ in outcome
- BUT ⇑ engagement
- AND ⇑ satisfaction

ACT is now undeniably in decline - several reasons cited in team closure business cases:

- English ‘hard’ evidence has shown that ACT does not reduce bed usage (Killaspy 2006/2009, Glover 2006)
- mixed results with local pre-post analyses.(Few areas collected routine outcome measures or carried out local evaluations)
- It is more expensive unless it reduces bed usage.
- We need to make savings (recession)

The Rise and Fall of ACT

Burns T. International Review of Psychiatry April 2010

- RCTs only show a positive effect on bed use for ACT where standard care has long lengths of stay
- Standard care has improved and in fact benefited from the intense research scrutiny and experience of ACT
- Low caseloads (expensive) do not correlate with reduced bed use in meta regression analysis
- Organisational aspects of ACT team working such as multi disciplinary teams, regular meetings and home visiting account for almost all the gains.
- These are no longer exclusive to ACT but found in standard community mental health care

ACT: A decent burial!

- The imperative now is to make sure that dismantling and integration is done intelligently preserving what is best in ACT and taking it into the standard locality team.
- Can the standard team operate more like an ACT team with shared care and high levels of coordination?

Part 3: The future: towards co-production

Moving from a Chronicity to a Recovery Paradigm

- Diagnostic groupings; “Case”; Lumped and labeled as “chronics”/ SPMI/ CMI
- Pessimistic Prognosis; “Broken Brain”
- Pathology/ Deficits; Vulnerabilities Emphasized; Problem-Orientation
- Fragmented Biological/ Psychosocial/ Oppression Models
- Professional Assessment of “Best Interests” and Needs/ Paternalism

- Unique identity; Person orientated; Person First Language
- Hope and Realistic Optimism
- Strengths/ Hardiness/ Resilience; Self-Righting Capacities Emphasized
- Integrated Bio-Psycho-Social-Spiritual Holism; Life-context
- Self-Definition of Needs and Goals/ Voice/ Consumer-Driven/ Self-determination

AQRP
Association québécoise pour la réadaptation psychosociale

ENTER Mental Health
European Network on Training, Education & Research in Mental Health

Paradigm Shift

- Patient/ Client/ Consumer Role
- Resource Limitations/ Poverty
- Helplessness/ Passivity/ Adaptive Dependency
- Normative Roles/ Natural Life Rhythms
- Asset building/ Opportunities
- Self-Efficacy/ Self-Sufficiency/Self-Reliance

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The Advent of Recovery Colleges: Principles

Driven by Centre for Mental Health

- **Hope**: ensuring the possibility that it is possible to pursue people's personal goals and ambitions;
- **Control**: helping people to maintain a sense of control over their lives;
- **Opportunity** : supporting people to build their lives beyond mental illness;

Recovery Colleges: aims

- Recovery Colleges deliver comprehensive, peer-led education and training programmes within mental health services.
- They should be run like any other college, providing education as a route to Recovery, not as a form of therapy.
- Courses are co-devised and co-delivered by people with lived experience of mental illness and by mental health professionals.

Recovery Colleges

- Currently six *Recovery Colleges* in England (2013)
- As well as offering education alongside treatment for individuals, they also change the relationship between services and those who use them
- Identify new peer workers to join the workforce; and they can replace some existing services.

Towards Co-Production

- Service Users as equal partners in collaboration
- service users have the right to choose their own care plan in negotiation with their key worker
- Service users as collaborators in provision of care, audit, educational delivery, review and purchasing

Towards Co-Production

- ‘a potentially transformative way of thinking about power, resources, partnerships, risks and outcomes, not an off-the-shelf model of service provision or a single magic solution.’ (Needham & Carr 2009 p.1)

- co-productive approaches provide ‘a way in which the professional’s knowledge can be converted into a catalyst that empowers’

Co-production indicators: levels

Crepaz-Quay 2014

- **Individual**
- The service/treatment goals are jointly set by professionals and service users

- **Operational**
- Service users deliver training in partnership with professionals
- Service users contribute to a professionally led training session
- Service users contribute to the production of official information
- The service has a regular meeting that service users can attend to get involved

- **Strategic**
- New services are jointly designed or co-produced by service users and professionals
- Several service users sit on the governing body

Centre de Co-production

- Provide an umbrella framework for networks, individuals and organisations committed to developing and advocating for co-production

- Aim to provide a national, regional and local consultancy, research and training resource promoting the application and evaluation of co-production principles and practice

- Provide opportunities for personal growth and development to people, so that they are treated as assets, not burdens on an overstretched system

Sustainability?: The Enablement Programme

There are a number of outcomes that are expected to be delivered as a result of this programme including:

- A decreased bed base
- Less admissions
- More people moving through the pathway to discharge within shorter timeframes.
- An enabling focus to recovery adopted and supported along the clients journey.
- Reduce numbers of people on care coordination pathways of care at any given time
- Enablement is the first point of contact for people accessing the organisation
- The organisation has a good reputation
- There is excellent feedback from both staff and people accessing the organisation

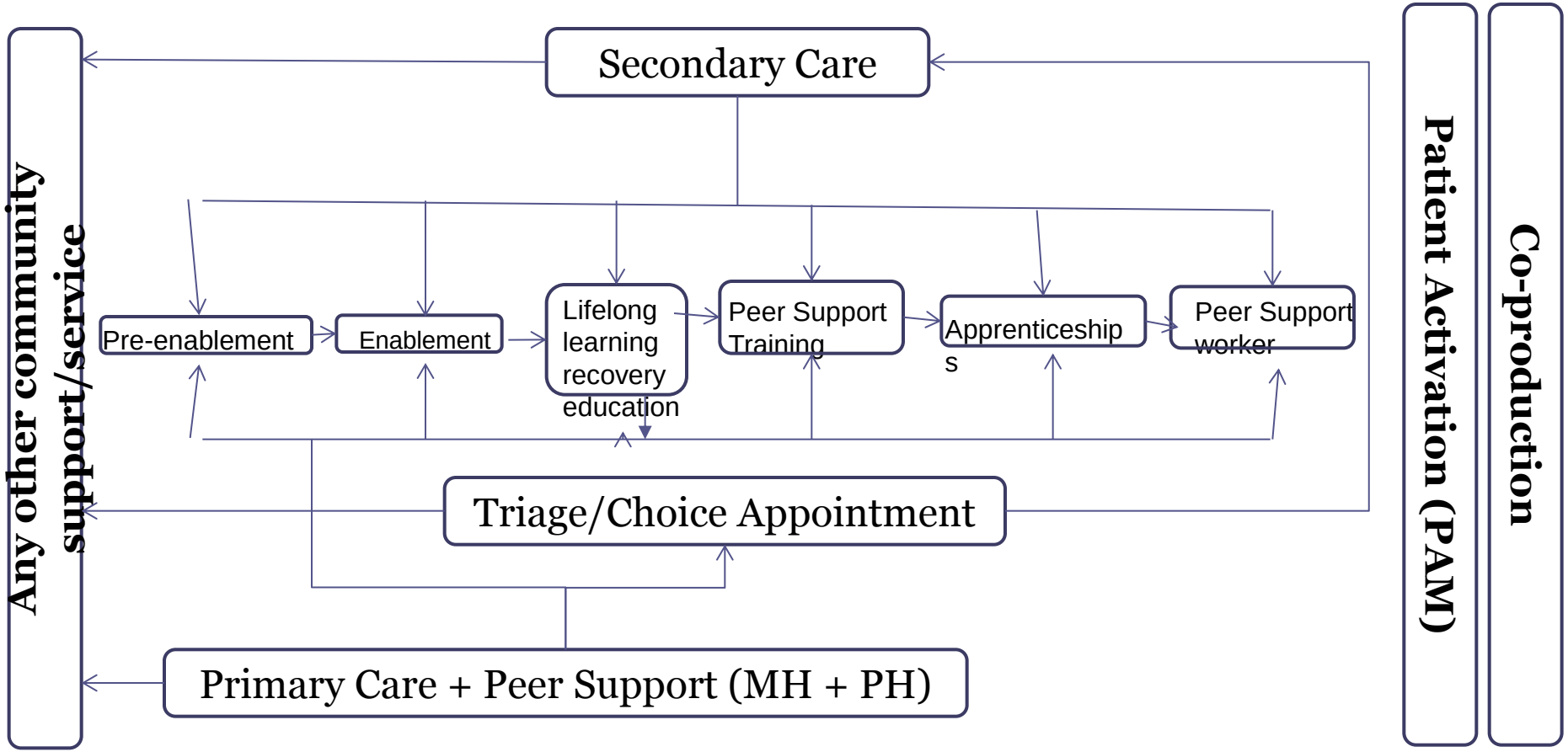
10 key challenges

No.	Challenge
1	Changing the nature of day-to-day interactions and the quality of experience
2	Delivering comprehensive user-led education and training programmes
3	Establishing a 'Recovery Education Centre' to drive the programmes forward
4	Ensuring organisational commitment, creating the 'culture'
5	Increasing personalisation and choice
6	Changing the way we approach risk assessment and management
7	Redefining user involvement
8	Transforming the workforce
9	Supporting staff in their recovery journey
10	Increasing opportunities for building a life beyond illness

Adapted from Implementing Recovery: A new framework for organisational change
[illegible], J and Shepherd, G. (2009) Centre for Mental Health

Enablement at BEHMHT

We will be basing our transformation on these 10 key challenges and are registered with imROC in order to link with other organisations who are working towards this model.


Secondary Care
Any other community support/service
Patient Activation (PAM)
Co-production
Pre-enablement
Enablement
Lifelong learning recovery education
Peer Support Training
Apprenticeships
Peer Support worker
Triage/Choice Appointment
Primary Care + Peer Support (MH + PH)

A dynamic model of well-being