Service models in adult psychiatry

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Executive summary

Mental health services have led medicine in the move from hospital-based care to care focused on supporting and maintaining patients within their homes and communities. Community-based care has itself undergone significant change, with specialist teams being set up for particular patient groups, for example perinatal services, eating disorder services and early intervention in psychosis services. In addition, specialist services have been set up for different parts of the care pathway, for example assertive outreach teams, access teams and treatment teams.

The Royal College of Psychiatrists' position on the separation of care between in-patient and community and within the community can be summarised as follows.

Decisions about the best model of service delivery should be based on evidence that the model will deliver better care for patients. Changes proposed should start as a pilot and be evaluated before wide-scale service redevelopment occurs.

The principles underpinning any change should be:

- to ensure ease of access by patients to services
- the configuration of services should deliver evidence-based treatment
- to reduce the risk of poor commitment: continuity of care is important for patients and
- patients must not be referred and assessed by different parts of the service before being provided treatment.

In the absence of certainty about best practice in service provision, geography, local expertise and historical service developments, different service configurations may deliver best outcomes in different areas.

In many parts of the country a separation of medical responsibility between in-patient and community teams is likely to be required. This is to ensure that in-patient services have sufficient senior medical time reflecting the acuity of the illness of current in-patients and the need for daily decision-making on in-patient units.

Notwithstanding the need to have a separation of community from in-patient consultant, continuity of care is key to safe and effective services. Patients value being looked after by clinicians whom they know and who know them and their history. This means that unless there are good reasons centred around patient care, community care should be provided within a generic community mental health team.

There are cases when evidence indicates that specialist services provide better patient care than generic services, for example perinatal services, eating disorder services and early intervention in psychosis services. Although these services do not provide care over years, they usually provide continuity of care over an episode of illness.

It is unlikely that services that arbitrarily distinguish between episodes of illness defined by time will serve patients well. It is also unlikely that services defined according to payment methods will stand the test of time.

Crisis services, however configured, must be responsive and have access to the resources necessary in terms of including adequate numbers of beds, sufficiently skilled staff and alternatives to hospital admission to be able to offer safe and timely care.

Introduction

Over the past 50 years, mental health services in Britain have seen, a shift from Victorian institutional care with its culture of paternalism and disenfranchisement, to community-based services, increasingly offered close to or even in the patient's home and an emphasis on partnership working. Like much of medicine, mental healthcare has been influenced as much by the zeitgeist and fashion as by evidence.

British psychiatry was an international pioneer in the development of multidisciplinary sectorised services prompted by the forward-looking Mental Health Act 1959. Important landmarks en route have included the development of community mental health professionals and the evolution of the community mental health team (CMHT). These have been accompanied by the evolution of ever-changing service models and approaches to address the need to provide more effective mental healthcare within a climate of variable fiscal management and tolerance of risk. As with Darwinian evolution, some of these approaches have become dead ends; some, although initially attractive, have proved unfit in the face of a changing environment or competition; and others have progressed to become accepted components of mainstream practice.

Psychiatrists have both championed new service models and defended traditional models of care. They have tried to rationalise their workload and embrace change; they have been motivated by a desire to provide the best possible care but differed on how this might be achieved. The result is a lack of uniformity within UK mental health services and the roles of the psychiatrists working within them. This is not necessarily a bad thing – and certainly no different to the situation in other European countries – provided all services aspire to and deliver equitable service provision and high-quality of care.

One important development over recent years is the increasing specialisation of services, with a move from sector-based provision of care where a consultant psychiatrist remained medically responsible for patients throughout their psychiatric journey, whether being cared for as an in-patient or in the community and for whatever the disorder. There has been a separation of in-patient care from community care, and a development of specialist teams in the community. This has been described as the functionalisation of mental health services.

The purpose of this report is to:

- provide an overview of how some aspects of functionalisation developed

- comment on emergent problems with and advantages of functionalisation
- suggest a principles-centred, rather than model-centred, approach to service development
- outline actions for the Royal College of Psychiatrists to pursue
- help commissioners and service providers, in outline, to determine whether or not to pursue a particular service development.

There has never been a 'golden age' of British psychiatry: services have changed periodically and with increasing rapidity over the past four decades, and will continue to do so. Nevertheless, it is important for psychiatrists (who may spend decades delivering care) – in safeguarding the interests of those who may spend decades receiving care – to pause and reflect on what they do. It is timely to consider these issues afresh in the light of recommendations of the Francis report (Francis, 2013). It is also important to note psychiatrists stay in post for longer than senior managers. Not only do they carry on institutional memory of what has or has not worked before, but are also left to manage the effects of change long after other managers have moved on.

For the sake of brevity, this report will largely confine itself to issues that are generally seen as the province of a CMHT: the provision of mental healthcare to people with relatively severe and enduring mental health problems who normally live outside of institutional care and are neither suffering from illnesses specific to advancing age, nor younger than adolescence. There are, of course, other specialisations in the psychiatry profession – by patient age (e.g. child and adolescent services, older people's services), by some types of subspecialty (e.g. forensic) and by some types of intervention (e.g. medical psychotherapy). Although there are common themes to consider when thinking about these subspecialties, they will not be the focus of this report.

Overview

The so-called 'functional split' probably emerged early in the first decade of this century as a pragmatic response to New Ways of Working and job planning for psychiatrists, contributed to by the rise of crisis teams acting as gateways to beds in compliance with the National Service Framework for Mental Health (NSFMH) (Department of Health, 1999). The term refers to a simple division of the responsibilities of the consultant workforce into primarily in-patient or out-patient care.

At the same time, new models of care prescribed by the NSFMH, together with later initiatives, resulted in the development of new teams such as assertive outreach, crisis response, home treatment, and early intervention in psychosis. These nationally prescribed services included a broad church of local variations under the same headings, as well as a variety of idiosyncratic local services, including 'access teams' and 'well-being and recovery teams' that have assumed the brief that was once that of the CMHT. These developments were accompanied by a small amount of new investment but most services were developed through the recycling of existing resources and staff, including consultants.

Some mental health provider trusts are currently working on redefining care pathways and allocating service provision to support the Department of Health's Payment by Results (PbR) clusters (Department of Health, 2013). This is despite concerns about the reliability and validity of the clusters. There is limited evidence for this model of care pathways related to needs-based clusters, and PbR is yet to be implemented, let alone evaluated.

One consequence of more specialist teams is the need for specialist consultants. Teams that have particular roles/functions in mental health services have been loosely referred to as 'functional teams', thus providing us with a second type of functional split.

It is proposed that a working definition of the functional split might be: 'different teams responsible for the patient's care at different points in the patient's journey through care'. This recognises the reality of a journey that can progress in a variety of ways and without the expectation that one team or clinician will provide continuity throughout.

Functionalisation: problems and advantages

Service models generally evolve either as a result of new evidence (e.g. early intervention services as a result of recognition of the benefit of reducing the duration of untreated psychosis) or through the application of a philosophy (e.g. recovery-based models).

Flagship services which develop new models are usually led by clinicians who are deeply passionate about a particular approach. Their leadership and commitment to making the model work affects the team culture, making it more cohesive, supportive and effective – in other words, making the service 'special'. As a cohesive group working towards a mutual goal this is very attractive, enabling clinicians to identify the boundaries of inclusion and exclusion criteria that define the sub-population served and thus protect themselves from escalating demand. Such services are typically underwritten by new money and research methodology, ultimately publishing claims for the new approach. It is generally the anecdotal experience that these service models do not perform well once the initial drive has evaporated, when upscaled to larger services, or when generalised to services that lack the specialist clinicians, incentives to publish, new investment or the same commitment to the model. Attempts have been made to evaluate situations where models of care developed by flagship services are delivered by non-specialists. It is difficult to design an adequately controlled study, although even when services retain 'fidelity to model' in real-world settings, results do not seem as good as those in flagship, innovative services (Burns, 2002; Killaspy *et al*, 2006). This must raise the question that services hinge on the quality of individuals in them, not the models they follow.

Problems

A fundamental problem with the adoption of new service models is that they are often not really new at all. The clinical interventions delivered are usually derived from existing practice delivered with a different emphasis. Where genuinely new technologies do emerge, they are quickly extended across the range of clinical activities: the use of clozapine and the widespread use of cognitive–behavioural

therapy are obvious examples. It is likely that the identification and use of medication to treat adult attention-deficit hyperactivity disorder will become a further example. By contrast, subspecialties in general medicine have cardiologists, for example, prescribing a very different range of drugs and interventions from gastroenterologists. There is also a real risk that simply transferring the lessons of a service in one specific area to a broader service setting and culture will not take account of the local service needs and demographics. Thus, services designed for inner-city London, Birmingham or Glasgow cannot be expected to transfer effectively to rural Dorset or Cumbria.

Further difficulties arise where the availability of new, 'pump-priming' investment, badged to particular types of service develop-ment, has seen the introduction of new teams to support new models of care. Multiplication of teams has adverse implications for the patient journey, almost always bringing internal referrals, repeated assess-ments, and the opportunity to raise patient expectations only to dash them on issues of service boundaries and specifications. What we know about patient safety, quality of care and patient preferences all point to continuity of care being the single most important element of system design. Fragmented services create interfaces which can be both inefficient and unsafe: every interface implies a referral at least, usually a discussion and often a meeting. A high proportion of serious untoward incidents involve problems at system interfaces. Teams often put as much effort into protecting their boundaries as they do into seeing patients, leading to friction between teams. With regard to quality, there is evidence from the psychotherapy literature about the value of consistent therapeutic relationships (Horvath *et al*, 2011). Moreover, patients and carers have been critical of repeated assessments and find fragmented services hard to navigate. National Institute for Health and Care Excellence (NICE) guidance on the patient experience states 'people using community mental health services are normally supported by staff from a single, multidisciplinary community team, familiar to them and with whom they have a continuous relation-ship' (National Institute for Health and Clinical Excellence, 2011: p. 7).

Advantages

The in-patient/out-patient split does have advantages. It is popular with in-patient nursing staff, as fewer multidisciplinary meetings are required and there are fewer consultants working to each ward, simplifying communication and saving time. The approach has been supported by the Royal College of Nursing (2013). In the context of reducing in-patient bed provision, the average level of 'acuity' in in-patient units has risen, with more patients detained and the reliable presence of an experienced senior clinician with a consistent approach is likely to be a major advantage. At the point of discharge, however, greater efforts are required to ensure continuity. This is especially important given that the first few days after hospital discharge have been found to pose greater risk in respect of suicide (Appleby, 2000). In addition, many

services have managed the expectation of 24-hour community-based care through funding these services on the basis of a reduction in in-patient facilities, most of the funding going towards resource crisis response and home treatment teams in the expectation that these will reduce in-patient need as identified from flagship services, although formal evaluations have not absolutely supported this (Joy *et al*, 2006).

The universal prescription of the NSFMH demanded a 'one size fits all' approach to mental healthcare delivery that failed to allow services to develop to suit their local environment or to benefit from focused local expertise. This is ironic since the flagship services on which it was based were developed entirely by local experts to fit the needs of the community they served. Anecdotally, the situation is further complicated by the fact that elements of the functional split have worked very well in some areas, whereas in others they have caused significant difficulties that are now being unravelled. So, for instance, it may be entirely appropriate to split in-patient and out-patient responsibilities if the in-patient beds are geographically remote from the sector served. On the other hand, in a small rural service, it may not be practical or desirable to have three NSFMH compliant teams for assertive outreach, early intervention and crisis response as well as a generic CMHT. This runs the risk of the CMHT becoming a denuded rump, able staff having moved on, or a 'dumping ground' overloaded by the other teams, with patients who do not meet their strict inclusion/exclusion criteria.

A way forward: the principle-centred approach

One way of resolving the problems attendant on the functional split and its various critics and proponents is to positively move away from the idea that there is a single 'ideal model' of mental health service delivery.

The truth is inevitably more complex. Services should develop models of delivery that provide robust evidence of quality in respect of safety, positive outcomes and positive patient experience. This is a timely assertion given the opportunity afforded by the Health and Social Care Act 2012 in England for commissioners to move away from an expectation of a nationally defined service configuration and, instead, to commission against frameworks that consider outcomes. Service development should be informed, for instance, by Joint Commissioning Panel for Mental Health guidance, professional bodies and evidence-based guidelines from, for example, NICE and the British Association for Psychopharmacology. It remains – and should remain – the responsibility of local services, via engagement in the commissioning process, to decide exactly how local services should be configured. A vital role of the psychiatrist, and by extension the Royal College of Psychiatrists, is to provide clinical leadership to ensure that however local services are configured, they deliver the right quality of service.

The principles and parameters of quality within which any proposed service model would be expected to operate should include the following.

- Services must be patient-centred and focus on the needs and recovery of the patient.
- Services must be responsive and timely, and provide appropriate timescales for response to emergency, urgent and routine referrals, with no substantial wait for routine appointments and no internal waiting lists.
- Services must be effective. A range of specific, evidence-based treatment and therapy modalities, appropriate to best practice in managing the clinical work of the team, must be offered by staff with sufficient experience, training and time. This includes

relevant skills and training in delivering a range of pharmacological interventions and psychological therapies as well as an understanding of the impact of social factors and how to influence them.

- Services must be safe and provide standards of care that ensure patients and their carers do not come to harm.
- Services must have access to the range of appropriate resources necessary to deliver the care required.
- Services must be caring and provide treatment with kindness and compassion.
- Services must be flexible and sensitive to the needs of patients. They must 'own' referrals at the point of access and have processes in place to ensure that patients are not left without appropriate support or fall between services. They must have a robust and audited protocol to ensure that disputes between different teams and parts of the service are escalated, in a timely manner, to a sufficient level that they can be resolved, and that patients' needs are managed within the referring team or the team that has taken the referral until such time as they can be passed on.
- Services must be prepared and be able to work across traditional age or geographical divides.
- Services must routinely collect clinically relevant patient outcomes and reflect on and respond to the results.
- Services must operate seamlessly with primary care and other partners.
- Services must be able to demonstrate that they are cost-effective and comparable with similar services on the basis of cost and value.
- Services must demonstrate a commitment to early intervention across the spectrum of mental disorders, but be mindful of the risk of overmedicalisation and the fostering of dependence.

What should the Royal College of Psychiatrists do?

Tools available to the Royal College of Psychiatrists to push forward this agenda fall into three groups.

Training

This tool needs to remain broad enough to provide a solid foundation for later skill development as service needs dictate. Indeed, there is a discussion to be had about a return to a single specialist training certificate. The College's traditional focus on pre-membership training needs to continue to broaden: the great progress made on continuing professional development post-membership and supporting revalidation are obvious examples of this taking place.

Increasingly, psychiatrists need to sharpen the skills underpinning their ability to influence organisational decision-making and relationship development. It is crucial that psychiatrists see themselves as champions of service quality. Psychiatrists need to become managerially numerate and articulate, and culturally prepared to advocate for high-quality services. The College should help psychiatrists recognise that these skills are as important for consultants as their clinical skills – indeed the College has begun to do so, for example by helping psychiatrists understand the skills and knowledge underpinning effective clinical leadership.

Job planning

The second set of tools relates to job planning. Models for psychiatrists working across different services – from having a full in-patient case-load to full community responsibilities with varying levels of specialisation – are under development. It is intended that these more sophisticated job-planning templates will help ensure that psychiatrists have jobs that are realistic and that will help support the delivery of high-quality care. The effective exercise of this will need College assessors to be developed and supported, and medical directors to be prepared to provide strong local leadership. Jobs that are too fragmented or too busy should not be supported. Jobs that do not

allow adequate time for training of supervision of junior staff where this is a requirement of the post should not be supported. Work has begun on this with the publication of *Safe Patients and High-Quality Services* (Mynors-Wallis, 2012).

Activities that help to deliver a broader influence

The third set of tools – and the hardest to utilise, although possibly ultimately the most powerful – relates to the College continuing to take part in activities that help it deliver a broader influence. This takes place at all levels – from a local level in discussions via informed members of the College with local commissioners, patient groups and other key partners, to a national level, in relationships with the NHS Confederation and the Department of Health. Francis speaks of this, stating that greater cooperation between the medical Royal Colleges and the General Medical Council, for instance, is required (Francis, 2013). It is at this level, working alongside partners, that the College can have an important role in primary prevention, by continuing its work in partnership with other stakeholders and agencies on the recognition of the impact of social factors and continuing to develop innovative responses to them, as well as campaigning for adequate resources to deliver safe and effective services.

What should commissioners and service providers do?

Those who provide mental health services and those who commission them already have a considerable number of documents, standards and imperatives to consider when developing services.

The College believes that services that deliver the right intervention to the right person at the right time are likely to be safe, effective and appreciated by patients who are being cared for in that service and those who work there.

When deciding whether to pursue a particular service development, commissioners and service providers will wish to consider the following questions.

- What is the rationale behind the service change being delivered? This will involve consideration of the prime drivers behind what is being proposed – for instance the introduction of a new treatment, extension of a service to a population not previously served or a remodelling to improve cost benefit. Intrinsic to this is a consideration of whether the service is truly needed, as opposed being put in place simply to attract a new funding stream.
- What is the evidence base behind the service development? It is vital that careful consideration is given to this, especially if what is under consideration is a new service model. Thought should be given to how well the characteristics of the model will fit with the local context.
- What changes to staffing will be needed and what changes to staffing will ensue? Those considering a development must ensure appropriate numbers of staff – with the right supervision, training and support – and where these staff will come from. If redeployed from existing services, what will be the impact on these services?
- How will the effect on patient care be evaluated?

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