Transforming mental health services†

David Kingdon

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

Impact of CRHT teams

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

Declaration of interest
None.

Funding issues

The policy overall has been intentionally inflexible, which has led to the imposition of a specific functional model on a range of community services. The advantage has been that teams based on the available evidence have been developed and established across England. Funding for this specific purpose has been spent as intended without being siphoned off by commissioners and providers for other purposes. Governments want to know what public money is being spent on and, increasingly, see evidence that it is achieving positive results. This means using routine clinical and patient-rated outcome measures (e.g. DIALOG7). If they don't have such information, they can and, in the near future, will cut funding: it is a lot easier to remove a percentage from a 'block' contract than cut from specific patient groups. The introduction of Payment by Results8 has to be seen in this context as a method of determining how the £1 in £7 of NHS funding that is spent on mental health services is achieving value for money. However, the system currently proposed is using 'clusters' based on an

†See pp. 71–76, this issue.
Kingdon demonstrated for early intervention.\textsuperscript{12} There also needs to be outreach\textsuperscript{10} and both the economic\textsuperscript{11} and clinical benefits will be lost, i.e. improved engagement of patients with assertive economies of scale, the gains that have been found with the teams some areas but there is a serious danger that in achieving compared with inner cities. Integration of teams is occurring in may be more appropriate in dispersed rural communities matching of resources to need, for example multipurpose teams for psychosis and borderline personality disorder. The disadvantage of the policy is the lack of flexibility in the programmes approach) which link to the existing evidence base could provide clinically meaningful and relatively homogeneous groupings for costing.

**Integration of teams**

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

**Care pathways**

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

**David Kingdon**, MD, FRCPsych, University of Southampton, College Keep, 4–12 Terminal Terrace, Southampton SO14 3DT, UK. Email: dgk@soton.ac.uk

First received 25 Jan 2011, final revision 19 Mar 2011, accepted 6 Apr 2011

**References**


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Access the most recent version at DOI: 10.1192/bjp.bp.111.092247

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