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KING'S FUND

MENTAL HEALTH SUPPORT GROUP TO THE LONDON COMMISSION:

DISCUSSION PAPER

"A CRITICAL EXAMINATION OF SYSTEMIC PROBLEMS IN URBAN MENTAL HEALTH CARE SERVICES"

System Pathologies in London's Mental Health Services

Contents

[*NOTE: Readers with pressures on their time could omit sections 3 and 4 and concentrate on the rest, this saves reading 25 pages]

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A CRITICAL EXAMINATION OF SYSTEMIC PROBLEMS IN URBAN MENTAL HEALTH CARE SERVICES

System Pathologies in London's Mental Health Services

1. THE FINDINGS AND "DIAGNOSIS OF THE SUPPORT GROUP REPORT TO THE LONDON COMMISSION

1.1. What follows is intended to take further the diagnostic and analytical work which has been produced by the King's Fund Mental Health Support Group for the London Commission. An Executive Summary of that Report is attached to this paper.

1.2. The central problem which we now face is that we have much better evidence about the pressures and difficulties of the service but do not yet have a clear strategy for engaging the field (managers, clinicians, purchasers, and the users/public) in a developmental process. In fact there is a danger that the reports' diagnosis might be thought to lead naturally to activity which will solve these identified problems or at least support remedial activity. It is my view that what the report has illustrated are in fact symptoms and effects of systemic underlying problems with the services. We can refer to these as "system pathologies". This paper is an attempt to focus on these pathologies and by using a conceptual framework about emergence, development, change and learning to move towards a more radical and fundamental approach to our engagement with the field. This paper is intended to provide the basis for a series of interventions in the field. It does so by attempting to open up a somewhat more theoretical and certainly abstract discussion about the nature and content of mental health care.

1.3. At this point you may wish to read the Executive Summary or continue on the basis of a selected reference to the key issues in the next few paragraphs.

1.4. The selection of illustrative issues are as follows:-

1.4.1. Mental health and social deprivation can be shown to be closely linked. Unemployment; homelessness; single person households; ethnic minorities; refugees; and substance abuse have cumulative effects on the number of patients requiring mental health services.

1.4.2. Social deprivation is also linked to the costly requirements for medium and maximum security beds.

1.4.3. Pressures on acute beds through Mental Health Act admissions coupled with high through-put and high bed occupancy levels are linked with severity of disorders; aggressive behaviour which create further dysfunctional pressures for both clinical staff and patients.

1.4.4. The needs of new long-term patients require further examination and their inappropriate placement causes certain in-patient facilities to be inappropriately used.

1.4.5. The delays in service provision are systemic both at identification, referral, admission, transfer and placement.

1.4.6. The absence of key elements in the spectrum of care causes existing elements to be inappropriately used and pressurised.

1.4.7. The specific needs of a variety of ethnic groups are not well recognised or understood. Help seeking and engagement patterns with mental health services are not well understood and they are particularly problematic within these population groups.

1.4.8. The interdependence, systematically of these elements in the spectrum of care requires detailed "mapping" to define patient and client flows across boundaries and to examine in detail substitutability claims of less intensive services for

maximum costing services. In particular, the elements of 24 hour community services, 24 hour staffed residential units, less intensively staffed units need careful co-ordination in defining this spectrum of care.

1.4.9. The whole area of day-time activities requires greater investment of high quality staff and inter-agency effort.

1.4.10. Configuration of Trusts and their relationships to PHC requires a radical re-appraisal. The initial process of sectorisation, CPA and creation of CMHTS are limited in their impact without significant shifts in service pattern provision in collaboration with PHC and Local Authorities.

1.4.11. Management capacity and capability is lacking; the service is over-tasked and undermanaged. Managers and Mental Health purchasers are under considerable pressure. Short-termism, lack of seniority add to these difficulties.

1.4.12. Clinical leadership, workforce planning and skill-mix issues have not been addressed in the current service developments.

1.4.13. A review of local resource allocation and purchasing plans in the light of their impact on the above problems must be completed before a critique of the national capitation formula and its impact on inner cities can be made.

2. A CONCEPTUAL FRAMEWORK FOR A DEVELOPMENT PROCESS

2.1. We now need to set out "bridging" material between these "findings" of the report and the development activity which might take place. In order to create this coherence, we require a conceptual framework which includes the following elements:

2.1.1. the various kinds of change that take place in organisations and complex systems;

2.1.2. a critical understanding of change which can relate both to intra-organisation change and change between organisations;

2.1.3. the nature of different kinds of "learning" and knowledge which may be required in different change scenarios and the assumed relationships between different kinds of "learning" and behavioural change.

2.1.4. The nature and focus of interventions that are being considered and the need for clarity about "whole system" interventions as contrasted with particular targets.

2.2. Firstly, we must make links between the "findings" of the report and what we term "system pathologies". I would define a "system pathology" as a definable pattern or set of circumstances that is dynamically played out, regularly, to produce inertia or system failure. The system failure is such that the primary task(s) of the organisation are subverted and significant resources are displaced in their focus of effort. A system pathology therefore has habit forming qualities (form) and will represent the struggle to attain goals (content) which are beyond the organisation's capacity, but which are nevertheless espoused as the goals of the organisation. Conditions in which organisations cannot do what they say they do, either because the implementation of the goals under any foreseeable circumstances would be impossible or because there is a lack of "fit" between the accounts given in the organisation about what they do (myths, culture and scripts) and what they actually do, are ideal for the growth of system pathologies. These two conditions are not of course mutually exclusive. This "unconscious hypocrisy" or defence against inevitable failure (or criticism) is not only internal to the organisation but may be well developed in collusive relationships with external bodies. In the NHS, for example, this may happen with purchasers, Regional offices and in provision of performance management data and regulatory inspections. The 'meta-world' of performance management creates a language and categories of evaluation which may have a tenuous link to the day-to-day realities of the organisation. In this case the system pathology does not reside in the existence of these categories as such but in their status and application in inappropriate domains of the organisations activity. This distorts the expression of the primary task (e.g. to

make a 6% return on capital) by describing it in language not used or understood as the motive for undertaking the work.

2.3. In attempting to describe system pathologies we might use the concept of an "archetype" where we seem to find chronic and persistent cycles of activity which entrap staff, clinicians, managers, and patients in sets of roles and relationships which become ever more rigid, sometimes defended but usually over specified and controlled. These cycles when experienced by those involved give rise to certain behaviours (tribal, defensive, risk-adverse, controlling, blaming, punitive, dependant and demanding) and feed a view of change **which always perceives change as a threat to the roles of staff, the task of the organisation and the well-being of the patients.** Mobilising passive-aggressive or defensive postures as a way of surviving and preserving the status quo gives rise to a dependency on existing structures and functions. This dependency is expressed as a kind of **"false necessity"** against which any change is viewed as both "risk" (to patients and/or public) and "threat" to staff roles (changing locus of work, style, etc.).

2.4. Mental health services have provided what is probably the most well known of such pathologies in the asylum as a closed institution. In fact, the fragmentary vestigial elements of that system break-up are still present in our current complex transitional era - e.g. the use and location of acute beds; the need for security; the "rehabilitation" of the concept of "asylum"; the role of the psychiatrist as admitting doctor; RMO; prescriber of medication; the "dangerousness" of "madness" as perceived by the public. The main reason for this is that all changes in mental health services have been seen as **changes away from the paradigm case of the "hospital-acute bed-psychiatrist-psychopharmacology" model**. Change, at least of some kinds, is a process of moving towards something and may be based on redefinitions of need, belief and creativity rather than well established empirically verified studies. It is unsurprising that change is characterised as "risky" or even irresponsible by those with a significant stake in the current system who conceive of "knowledge" as that which can be known only by a natural science methodology, and adopt a view of change which is:

2.6. For our current purposes the box "organisational goals" can be thought of as the concept of the **"primary task"**. System pathologies originate in all parts of the diagram but become systemic **when they interact such that there is a tension between identity and role, and the account of the organisations primary task.** Mental health services have a number of potential tensions which can and do develop into chronic pathologies rather than sources of creative diversity. A central feature of the dramatisation of these tensions (in what becomes inevitably over time covert and unspoken processes) is **the competition over the interpretation of the primary task in relation to the actors role and sources of identity.**

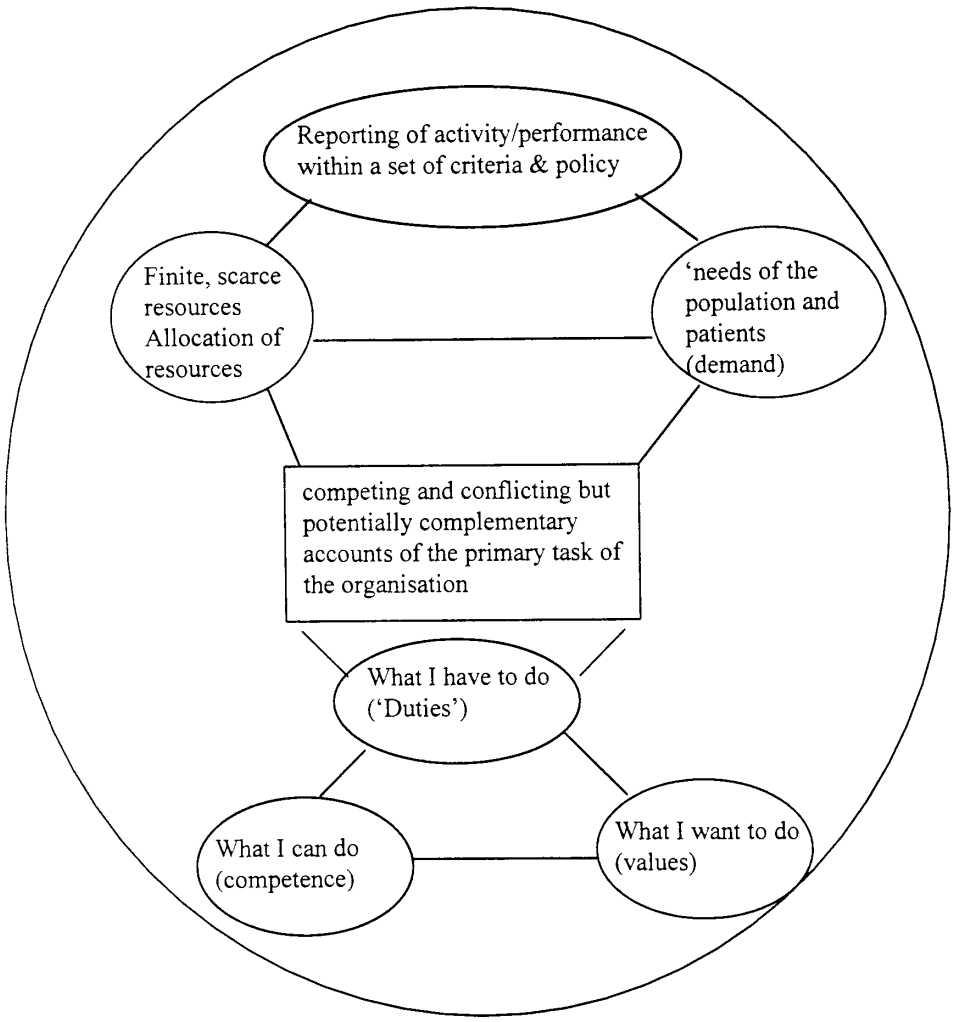
2.7. We can however understand organisational structures as spaces and places within which the members of the organisation seek meaning. We might therefore consider the narratives which emerge from a study of the users of the services. The very process of validating the utterances of users provides confirmation that we are far from understanding the experience of mental disorder; its manifestation within different social contexts; help seeking patterns; and the quality of life aspects associated with various kinds of service use. **Patients also seek meaning and do so partly by offering (competitive) accounts of the primary task of the organisation which treats and cares for them.**

2.8. It is not the case that these aspects cannot be made the proper focus of scientific enquiry. It is however a proper preoccupation in the disciplines associated with organisational change to ask the question as to whether it is preferable to seek "proof" before promoting change (a diagnostic, linear approach) or whether **organisational development can be more productive, by the use of more creative and emergent processes which embody the changes in the actual, very people for whom the change is intended.** This approach brings patient and user narratives into focus.

2.9. Mental health services display to detrimental effect a feature of organisational life which is that **the way we think about what we do, the way we do it, and the stance we take in doing it involve us in giving an account of the organisations enterprise in such a way that a variety of perspectives (meaning systems, discourses)**

compete for space, validity and dominance. This paper attempts to explore how the pathologies that get set up when we do this may in fact contain the seeds for a greater tolerance of both emergence and diversity which may be perceived as more collaborative and less competitive and conflictual. This tendency for narratives to compete and conflict is shown in a bounded space in diagram 2.

Diagram 2


Reporting of activity/performance within a set of criteria & policy
Finite, scarce resources Allocation of resources
'needs of the population and patients (demand)
competing and conflicting but potentially complementary accounts of the primary task of the organisation
What I have to do ('Duties')
What I can do (competence)
What I want to do (values)

2.10. The following "system-pathologies" seem to be important in mental health systems, they are tendencies both to produce forms of activity and in some cases to determine the content:

Pathology I CIRCULAR PROCESS IN RESOURCE ALLOCATION

2.10.1. The over-reliance on resource allocation by a capitation funding system based on disputed models of demographic need. User "needs" are aggregated and pre-classified by the use of a notion of a "spectrum of services". We calculate what we should have by the type of services we historically have created and measure and define needs accordingly as a circular process. We can only therefore agree to fund on the basis of more of the same. This is taken further by the use of a currency of 'FCEs' to determine effective activity levels.

Pathology II THE TENDENCY TO 'FIX' WHAT EXISTS

2.10.2. The covert, competitive, but unresolved, tensions between accounts of the nature of mental disorder and therefore what the primary task of a mental health organisation should be. The focus in current debates in the **middle ground** of **structures** (forthcoming Green Paper) or **"models" of care** and **process conformance systems** (eg CPA) takes place at the same time as absence of active debate on **causation** (origins of and the nature of the mental disorder imported into our transformational process), or on **innovation** (unthought of futures which cannot be unlocked by the current actors). The middle ground represents **expediency** and a remedial stance whereas looking backwards to root causes and thinking of new possibilities represents a **radical stance**. Control and risk of adverse tendencies have produced a middle ground in which mental health services are drowning in standards and protocols. This unnecessary uniformity and process control drives out clinical freedoms which when exercised responsibly will produce ideas and energy about how to respond to the user's needs. (See also para - page 18).

Pathology III THE SEARCH FOR IDENTITY (WORTH) PRODUCES ROLE RIGIDITY

2.10.3. The interlocking relationships within mental health professions between theory, training, identity, role, status and reward. The theories of the natural sciences, the "medical model"; behaviourism; neo-marxism; psychodynamic theory; systems theory, and diluted versions of these which appear in management "theories" and nursing, are in many cases intrinsic, and a **defining characteristic of the person-in-role in mental health organisations**. The reaction formations which occur when the organisation's equilibrium is threatened are powerful because of this composition of the work "persona" of mental health professionals. Different identities desire different roles, and although different roles can contribute to diversity and clear job definitions they can also create perceived threats and 'turf' wars. Unnecessary and over-rigid role boundaries produce unnecessary referrals between parts of the whole; unnecessary referrals are extra transaction costs.

Pathology IV THE ONE SIDED COIN: HEALTH "VERSUS" SOCIAL CARE

2.10.4. The poverty of theoretical analysis behind the oft quoted major boundary problem in the mental health services. This is referred to as the boundary between the "health" service and local authorities; or between "healthcare" and "social care". This refers to both the structural arrangements which are thought to be dysfunctional, and to the "models" of care provided by these organisations which when they work as complementary aspects of care are effective, but which more often compete for resources. The underlying theoretical basis for the "conflict" is rarely noted. It can be traced to quite different sources. The health care system defines "wellness" of patients as being controlled, maintained on medication or symptom free. Success is to create the best base-line for personal autonomy, liberty and freedom. This is usually thought of as a concept of "negative freedom". The theoretical stance of the agent of the local authority/social care system however is likely to be based on a "positive" notion of freedom which begins to specify the conditions

under which symptom-free autonomy can be exercised. Since people with mental health problems are citizens, employees, parents etc the question of what should be done with and to patients/users receives a broader substantive reply from the social care actors than the health care professionals. The system pathology is further driven by the respective allocation of resources to these enterprises. The resolution of this underlying cause is to recognise that there are two sides to the coin - **the individual treatment of mental disorder; and the social pursuit of mental health.**

Pathology V THE ACUTE BED: A NON SYSTEMIC FOCUS

2.10.5. The focus on single elements in a spectrum of care, e.g. acute beds, without recognising the inter-dependence of other parts of the system. The acute bed problem is proffered as the most acute problem;

Pathology VI PRE-COPERNICUS: IN THE INTERIM, COMMUNITY CARE IS AT THE OUTER RIM

2.10.6. The sense of the acute bed(s), wards, hospital and concentration of medical expertise as being the **"centre"** of the system around which other elements revolve. From this results the notion of "outreach" (assertive or otherwise) and the creation of intermediate structures such as "CMHTs" as attempts to manage a set of issues - SMI; PHC led NHS; inter-agency activity. This arena and set of interfaces creates one of the most complex and pernicious of the system pathologies; and is explored further in this paper.

Pathology VII EXPORTING, ECR COSTS LINKED TO LOW HOMEGROWN SERVICES

2.10.7. The exportation of patients out of administrative districts where they could be cared for, on the basis of severity and dangerousness creates high cost ECRs. This is non-community based and creates a returning boundary for re-entry into generic systems which have, because of the "export" practice itself, less capacity and funding for dealing with such patients;

Pathology VIII CONFUSING EXECUTIVE ORGANISING WITH CLINICAL LEADERSHIP

2.10.8. "Management" capacity and capability and the "clinical leadership" and the relationship between these two functions. Implicated here is the problems of the purchasers/provider split and its impact in mental health; and the role of the profession of psychiatry in mental health services. Confusion between management and clinical leadership is particularly common in mental health services.

Pathology IX PATERNALISM AND TOKENISM IN A SERVICE CULTURE

2.10.9. Mental health has a persistent service based culture and paternalism towards users of services, and ambiguity in practice about terms such as "empowerment" and "consultation". A service culture in human services tends to define client 'need' (by both type and quality) as the ability of the service to meet it. This culture manages entry to services/goods by gatekeeping which is a form of "priority setting " which is a form of rationing. The tendency to see services as goods encourages the commodification of helping transactions. The language of "choice" and consumerism in mental health services fuels the notion of "rights" to services which have a fragile basis in our constitution which is based on discretionary statute interpreted by public authorities. The cultural and ideological mix of public service and "80s" consumerism has had confusing consequences for the nature of relationships and transactions in mental health services. The confusion persists in the management of designed services as building blocks of a spectrum of care where the tensions between efficiency ('best' use of resources) and effectiveness is played out. Since our understanding of outcomes and therefore effectiveness is poor the emphasis is placed on the allocation of resources largely by a structural input approach.

We have neither witnessed the results of a full blown voucher system and learned from the user as "commissioner"; or allocated the block budget to a body with a user majority vote, or created co-operative highly participative processes for resource allocation. Instead we are trapped, and this is the

"system pathology", in the "push-pull" effect of irreconcilable ideologies. Our solution to this tension has been to produce a mixed service culture with forms of "care management" which produce too many "travel agents" and too few "travelling companions".

Pathology X THE DOMINANT THEORY; DOMINANT PROFESSION

2.10.10. Prevailing orthodoxy in academic institutions in teaching and research on reductive and deterministic theory to explain and evaluate mental disorder and the services provided. This "closed" system of thought interacts with medical status and career progression; this in turn interacts with the relationships noted above and becomes self-fulfilling. Since this is the most powerful meaning system, it creates a pervasive "engine" for most of the other system pathologies. We might refer to this as the nature of power and influence within the mental health polity.

Pathology XI QUALITATIVE FEEDBACK INTERACTIVE PROCESSES AND ORGANISATIONAL REFLEXIVITY

2.10.11. There is a need for greater balance between theoretically different types of scientific enquiry. The most rigorous methodologies tend to be applied to the type of research design that quantitatively measures the impact of activity located in the past and in which conditions are relatively static and where unknown or flexible variables are kept to the minimum. If it is the case that 'needs' of patients are constantly being redefined, articulated in new and different ways, and that new needs are also emerging then few variables are static. Needs, rights. expectations, the law, economic conditions are changing rapidly. This requires two kinds of responses, firstly the predisposition and ability to allow service functions to be determined by a dialogue between users of the service and providers so that new functions determine new structures and draw resources from other parts of the organisation. Secondly we require more research designs which are compatible with a developmental process, such as qualitative action research located in an R & D framework. The challenge is how to "research" the process and outcome of creating, innovating and change where the very criteria of evaluation may be changing and being

redefined by and in the dialogue to which I have referred. The design challenge for such a methodology is to make it easily available so that it becomes part of the change process itself, and so that its findings influence the process.

Pathology XII **DIALOGUES WITH USERS CAN REDEFINE NEEDS AND SERVICE STRUCTURES**

2.10.12. Mental health services tend to have an "arms length" quality of user participation and consultation around resource allocation and service planning. The tokenism and compartmentalisation of user consultation processes take the focus away from the dialogue about needs (and the potential effects of empowered choice) within therapeutic and helping relationships. The "working through", "coming to terms with" and the "becoming" process of helping relationships in mental health services are also sealed off from a process of service responsiveness and adaptation. Mental health services are unusual in that they are challenged to shape a person-centred **service** (structures) around sets of **helping transactions**. The system pathology here derives from splitting these domains and thereby cutting off sources of "data" to the service system. This results in two unexamined assumptions; firstly that the helping relationships (clinical activities) have to go on in some sense within a service structure rather than actually being the service itself. Secondly the illusion that the nature of mental health needs are not being constantly re-defined almost to the point that we might say that the nature of mental disorder is constantly being re-defined. These two features are of course inextricably linked.

2.11.In short, we could characterise these pathologies as:

2.11.1. The failure to understand the **political economy** of mental health and the nature of mental health needs in the context of citizenship; productive processes and ordinary life.

2.11.2. The failure to think **systemically** about the components of a system and their interactions. The historical legacy of the asylum, the "false necessity" of the hospital/bed as the "**centre**" of the service;

2.11.3. The defensive and dysfunctional aspects of professional **role rigidity**;

2.11.4. The creation of **iatrogenic services** and dependency; the invalidation of users narratives, meanings and capacity for autonomous action in partnerships with professionals;

2.11.5. The narrowness of theory; the close association of particular theories with particular professional groups; and the self-fulfilling application of a single dominant explanatory paradigm and its effects on the locus of **power and political influence** in mental health services. These links impact negatively on aspects of (clinical) leadership and management capability

2.12. In even shorter form, we could "tag" these pathologies as:

- political economy
- non-systemic approaches
- role rigidity
- iatrogenic services
- power, concentration of political influence, theory, role and status

2.13. There are of course complex system dynamics in the way in which these system pathologies are actually "played-out", that is to say, are dramatised by the

protagonists. Some of these dramatisations have a ritual quality and involve competing descriptions of the realities of particular services by those concerned with them. So although the 5 "types" of pathologies have been identified, in practice, they interlink and take many forms. A case study example is attached to illustrate one example. The system pathologies identified have some explanatory value both in terms of their origins and their effects. However, even this level of analysis is still limited by it being a "diagnostic" stance. It may be that we require to develop mental health services involving both remedial activity of some current activity, and also radical changes, some of which may be rapid, disjunctive and uncertain in outcome. A overarching pathology seems to exist in mental health systems which is about "change" itself. **It seems that little can change that is not an addition to the satisfactory running of existing services.** The problem with this approach is that it may be the case that existing services can never run "satisfactorily" either in systemic terms or in the view of the main culture carriers of the system (mainly doctors and nurses). Maybe caring for people with mental disorder within our existing system will always be "unsatisfactory" at a curative level. The interplay between the nature of mental disorder itself, the structure of the care system and the prevailing or dominant therapeutic theory is central to this over-arching pathology. The better understanding of the nature of mental disorder is likely to be found in the domain of patienthood, disability, marginalisation and stigma where individuals are objects acted on by the system. A better understanding of the care system will be found in organisational analysis, and the nature of systems where policy, resources, structures and practices are frequently incompatible. A better understanding of the limitations of the dominant ideology will provide diversity, pluralism and varieties of responsibilities for staff, and encourage new form of leadership.

2.14. I have set out elsewhere some thoughts and findings about change processes in mental health. The findings from a 35 Trust project on Organisational Standards showed that **there are significant imbalances in the input effort against measurable outcomes of a "standard-setting" approach to change in mental health units**. This is consistent with the description of the overarching system pathology in mental health services which tends to place remedial activity and problem solving, in a prior and

serial relationship to developmental progress. We require therefore a framework which has three basic features to assist with the focus of intervention.

2.15. Firstly, the framework requires to encapsulate behavioural change at practitioner level through to structural change. Secondly, the types of change being promoted require some detailed description. Thirdly, the ways in which staff and users participate in change and their personal development needs whilst doing so require further description.

2.16. I propose therefore that the following outline might be the basis of working on a developmental intervention strategy with mental health organisations.

2.16.1. For the organisational levels, the Klein and Eason (1) framework of the following be used:

- person
- roles and relationships
- situations, culture and context
- structures.

2.16.2. For the types of change and the management and personal development challenges, the framework of Blackler (2) can be used.

2.17. The framework can be used by "mapping" on to it the actual changes which are envisaged for an organisation and then considering their impact at the various levels of the system. The framework can also be used to consider the kind of development interventions we might make as external "change-agents" in helping mental health organisations face challenges in these areas. (I do this in section 5).

My assertion here is that all three kinds of changes occur simultaneously and, in most cases, will compete for resources.

Diagram 3

Development Levels ▼	Types of Change ▼		
	Remedial/Incremental	**Rapid Transition**	**Long-Term Uncertainty**
Person Role/Relationships Situations Structures			
Managerial Challenges ➡	Problem solving Managing Continuity Improving Performance	Competition Re-direction Disjunction Vision	Responsibility Values/Beliefs Leadership Innovation
Personal Development ➡	Use of Knowledge Existing Criteria	Unlearning Re-framing New Criteria	Collective learning and creativity Imaginative responsiveness

2.18. This framework will require considerable discussion if it is to be useful in designing possible partnerships with development sites. I believe this is worth doing.

2.19. In using this conceptual framework we need to recognise that organisations may display at any time all three kinds of change processes or any combinations of them. It is necessary for effective practice for the organisation to be able to identify which approach to change is likely to produce most benefit for the users or patients. I have already noted that these kind of changes or approach to changes will compete. This competition often takes place between people who have preferences for the different kinds of approach. The culture of the organisation as a whole will derive partly from its members' preferences and even norms in relation to these changes or approaches to change; the degree to which there is competition between these approaches; and the degree to which these tensions are located in individuals, roles, situations or departmental/directorate/HQ structures. Therefore the framework is not intended to be developmental, in the sense that by starting with improving performance (left, 1st column), that organisations will move on in some national progression to the other two. Neither is it the case that the proposal is to throw "caution to the winds" and embark on the most complex and difficult kind of change in the third column (right). The ability to function simultaneously in all three, discernment of what circumstances will be most propitious, and a workforce skilled, willing and flexible to move in these directions are all prerequisites of the adaptivity and reflexivity. A key focus in considering the capacity of the organisation to achieve its potential will be the level at which the preparation begins. A dilemma will present itself in the following way; do we encourage change at the personal level first, or do we make - decisive and "unlocking" changes at other levels (perhaps in structural or manpower terms) and present the workforce with the challenge of working under new conditions. The answer to this dilemma is once again contained in the framework; that there must be **coherence** at the four vertical levels of the matrix, person, roles, situations and structures if change is to be successful.

3. MANAGING COMPLEX SYSTEMS IN MENTAL HEALTH

3.1. There are a number of theoretical approaches to complex systems which can be brought to bear on mental health systems. In this next section I consider how **managers** in particular can approach **complexity** in mental health systems.

3.2. It is difficult for managers of mental health services to focus on whole systems for the delivery of comprehensive care when their own organisation is under stress and pressure. The dilemma of what to maintain, preserve and, if necessary, defend and where to allow or promote change and innovation becomes increasingly problematic when resources are scarce. The simple approach which maintains one's own organisation and looks for change externally in the other parts of the system is untenable.

3.3. On the basis that there is nothing so practical as a good theory, I examine here the contribution to our thinking of some aspects of systems theory ('parts' and 'wholes'), chaos theory ('bounded instability' and adaptation) and psychodynamic theory ('task', 'role', and 'boundaries'). I have added to these the concepts of 'relational space' between parts of a system and 'inner space' within organisations. I have already suggested above that metaphorical space can be contested. (see diagram 2, p.11). The focus in this section is on a system which we think of as the comprehensive mental health service. The perspective is that of an NHS provider.

3.4. Central guidance, driven primarily by the Care Programme Approach, the legislation on supervised discharge and the register, points NHS providers towards responsibilities beyond what some would see as the traditional confines of health service provision. The only way to act effectively beyond this 'boundary' is to develop multi-agency working and high levels of collaboration.

3.5. Central guidance has stressed the need to focus on the severely mentally ill, but has a key policy strand of promoting a primary-care-led NHS. Mental health managers are

struggling to square this circle and make delivery systems such as Community Mental Health Teams (CMHTs) compatible with the identification, referral, treatment and purchasing behaviours of GP fundholders. The multi-agency approach and these two policy strands suggest that the spectrum of need in mental health may require a variety of different businesses with different kinds of leadership and staff skill mixes to be considered comprehensive.

3.6. It is this increasing diversity in mental health care that is so challenging to mental health managers and problematic to non-mental health professionals. If trusts were purely in existence to treat the paradigm case of the psychotic patient who needs an acute bed then we would expect that clear definitions of disorder would lead to a logical targeting of resources, and established thresholds for admission and discharge. However once the service model is expanded to include the pursuit and maintenance of mental health in a social context, the management variables are greatly multiplied. They include issues like poverty, housing, education, and social services over which most NHS managers have little control. The management of acute beds is not unaffected by these factors.

3.7. Mental health organisations are under considerable pressures. These can either be perceived as threats to stability or sifted to identify an emerging order in a part of the service which may diminish the need for maintenance of in other parts of the organisation. An example of this would be in the changing demands and role of primary health care. Do trust managers create new business with these new players? Do they negotiate protocols for dealing with them? Do they assign CPNs to practices? Do they draw CMHTs closer to the primary care team? Do they invest in generic mental health workers across primary health care? These are just a few options that will arise as one part of the mental health system creates turbulence. Trusts responses to the patients movement, to advocacy and not-for-profit and private sectors will similarly produce long lists of possible options and responses.

3.8. What is common in these familiar scenarios is the dilemma for managers of what to promote and change and what to defend and maintain and the ability to predict and avoid consequences which produce failure in the system. This dilemma is often

conceived as one of strategy, or some would say misconceived depending on our notion of what it is to be strategic.

3.9. The turbulence in mental health systems and in their constituent organisations has characteristics of complexity, uncertainty, and conflict.. Managers therefore need ways of coping with these conditions without either defending structures in a risk adverse way, or swallowing whole the concepts of chaos theory and assuming that whatever patterns emerge are somehow both disconnected from their values, purposes and intentions and are also deterministic.

3.10. The turbulence itself has a number of sources. The existence of multiple theories and professional adherence to different theories and practices interacts with structural power and clinical responsibility in many ways. Few managers have the luxury of being able to scour the R&D literature to establish in their own minds what of proven effectiveness should be maintained and what innovations show better outcomes. Mental health services are usually an uneven patchwork of elements which have emerged through local history, from past leaders, from fashions and enthusiasms. Managers inheriting these organisations are subject to a range of clinical advice, have to be concerned about risk management, and have to be guided by central guidance all against a backdrop of low public confidence in "care in the community" as one of their central activities. As a result they and their organisations are often criticised about the activity over which they have least control. The hospital-community tension is now less ideological but is now contained within the NHS provider organisation, rather than projected on to different agencies or professions.

3.11. Expanding on the internal dynamics of trusts more forcefully we might say that the hierarchical structures of trusts entail two particularly powerful additional forces. Firstly the centralised common service systems of such things as information technology; information itself and the direction of its flow; financial management; training; and human resource management. Secondly the combination of the perceived part played by acute beds (the most expensive single item) as the 'core' of the service which interacts with the in-patient role of the consultant psychiatrist. The defensive investment in these two elements of the organisation may however deny the "CMHT"

type of function, both the capacity to become an effective local organisation in a self sustaining way, and clinical leadership. When these conditions apply, internal tensions sap energy. The competitive, defensive energy used in maintaining these 'central' structures and processes could be thought of as a kind of internal transaction cost. It also inhibits change. The shift in the focus of effort of the provider within the overall mental health system, can not be better achieved only by dealing with these internal displacements of effort. Trusts who aim to make a major contribution to "care in the community" are in some cases therefore willing the end but denying constituent parts of the organisation the means of achieving it.

3.12. What theoretical perspectives can assist mental health managers in thinking about these dilemmas?

3.13. The concept of 'chaos' in systems and organisations can be summarised as follows. Our traditional linear conceptual models of cause-effect have been shown to have decreasing predictive value within systems and organisations. If organisations are viewed as transitional structures constantly in the process of response to their environment then their capacities for survival and change will be based on adaptation and renewal. Managers who promote diversity, drive information through the system, and encourage feedback will lower controls and encourage new patterns and order. Strategic management is identifying those patterns. The theory goes further to question the value, in the long term, of strategic intent since the theory posits that as purposive managed activity moves forward control is traditionally exercised by identifying deviation (from negative feedback) and taking corrective action to maintain "course". Chaos theory suggests that positive feedback, i.e. knowledge of factors creating greater disequilibrium and deviation can have the character of creation and open up wholly new options and patterns. Systems and organisations which strive towards equilibrium use considerable energies to maintain structures and practices. The idea of emergent strategy (seeing patterns as they emerge and acting on them) is directly linked to the phenomena of positive and negative feedback which is the data which enables us to sustain the organisation in the borders between stability and instability, that is in "bounded instability". Stacey, one of the recent theorists bringing

such theory together with strategic management could be describing a mental health organisation when he says:

> "... organisations are paradoxes. They are powerfully pulled towards stability by the forces of integration, maintenance controls, human desires for security and certainly and adaptation to the environment on the one hand. They are also powerfully pulled to the opposite extreme of unstable equilibrium by the forces of division and decentralisation, human desires for excitement and innovation and isolation from the environment."

3.14. These are two key issues which emerge from these kinds of theoretical assertions.

3.15. Firstly if managers take the theory seriously how will they think of their intentions, purposes, and responsibility for what emerges? Secondly do patients and clients, and staff working in organisations maintained on the borders between stability and instability find their creativity and capacities enhanced or are they disabled by anxiety and adopt defensive routines for dealing with change?

3.16. I now turn to two literal and metaphorical domains where chaos theory meets psychodynamic theory, in the concepts of "boundary" and "space", and we explore how useful these concepts are for managing mental health services.

3.17. What do we mean when we talk about 'boundary' problems for organisations? We mean that conditions at the boundaries of systems are critical for the inner safe bounded 'space' and transitions across boundaries are key events. In dynamic rather than systemic terms we could say that people using a structured care system will benefit from experiencing support, a sense of safety, and minimal anxiety in the "space" and context in which they receive care. We discover how complex this is when we consider how CMHTs function. They have a composition drawn from different disciplines. This suggests a skill-mix which should increase flexible responses and choice for users. However when we look at the roles that members of such teams play they are often determined by the sense of their professional identity and employer accountability rather than their relationships within the team to the primary task of the

team. They pull towards the centre of their profession or towards external accountability. Leadership of such teams is often ambiguous. Is it a form of clinical leadership, team leadership, or management? These factors are not conducive to the creation of a clear well bounded "space" because in a sense the 'team' members themselves violate the 'boundary' of their system.

3.18. What is it to lead and manage such a team? Some key questions arise; will it's responsibilities be coherent in respect of other agencies? How will it relate to sectorisation, to admission and discharge of its patients to and from acute beds? Will its geographical area be consistent with other agency boundaries? Will epidemiological and social deprivation data be available to it to add to case-mix and activity data so that a local neighbourhood approach can be developed? Will it be able to balance the focus on severe mental illness and the desires of GPs?

3.19. Few "CMHTs", which are one of the key planks of most community care systems, have sufficient management capacities, coherent team roles, clear primary tasks, degrees of freedom and resources and are therefore unlikely to be able to adapt to the local environment. Senior managers in mental health are faced with a difficult choice. We have suggested that there are structural tendencies which deny "CMHT" activity organising capacity. Managers can either tool up local structures in management terms to be effective teams in both a clinical and a business sense, or run a set of central services (IT/human resources/finance/information) which are available to local teams but where the teams rely on a variety of professional perspectives to determine the functioning of the team.

3.20. If we take seriously the idea of turbulence and change should we not look to these parts of the mental health organisation to be displaying some of the feedback data noted earlier? Not to suffuse these structures with information and the capacity to change and not to deal with their lack of autonomy is to prevent them from adapting and evolving for, and as the organisation.

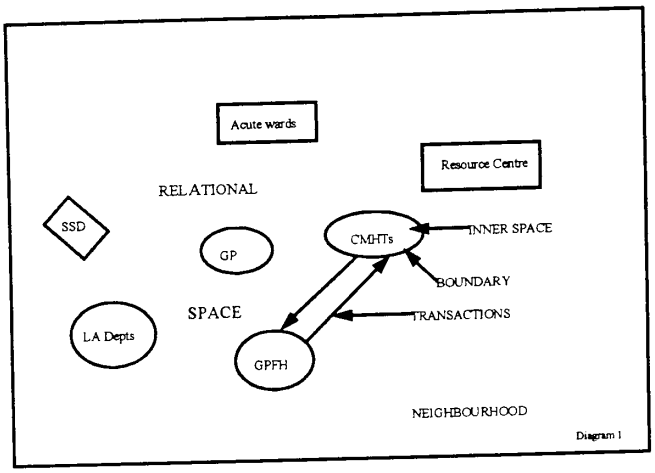
3.21. The shift in thinking for mental health managers may therefore entail several procedures:

- to equip the "CMHT" function with a self sustaining capacity
- to chart the effect this has in the whole system and in their organisation

and this will lead to a move towards the management of the relationships between the parts of their organisation which interacts with the environment. This may also be the road to greater local autonomy and accountability and creates a perspective on the nature of inter-agency working such that it is the 'relational space' between the components of a comprehensive service that become the focus of strategic leadership. We could imagine that these peripheral parts of the organisation may cease to be peripheral. The "CMHT" could purchase the acute beds within the trust structures and this may determine the number and location of acute beds.

3.22. So far the metaphors of 'space' and 'boundary' have suggested that the 'space' between parts of a system, between agencies or parts of organisations are where key transactions take place and are a useful focus for management. Managers could focus on the "relational space" as the arena for adaptation of their organisation. The idea of the "bounded inner space" provides the idea of safety and a context for helping relationships. In user terms the first kind of 'space' (between agencies) is where I may get 'lost' or fall out of the service I need, the second kind of 'space' (within services) is where I may or may not feel supported, contained, and safe. The suggestion here is that "CMHTs" in the way in which they are constituted, led, and given resources are not enabled to function adaptively in relation to their environment. This creates a series of stable problems in the way they relate in the 'space' within their host organisation, between themselves and other agencies and in terms of their internal dynamics.

3.23. The idea, of 'relational space'' which is the arena for adaptation to the environment can be diagrammatically expressed in the following way:



3.24. A Trust CEO inheriting a mental health service to run is naturally attracted by the idea of being clear about what components of a comprehensive mental health system ought to be in place, so that he/she can give his/her energies to supporting staff in being clear about their primary task, roles, boundaries and effective transactions with other organisations. However, even if all the pieces are in place there is little point in using management effort to maintain a 'boundary' of an organisation or part of an organisation that ought to be in transition. The contribution of 'chaos' theory is to assist in identifying possible answers to the question of what are necessary structures by encouraging adaptive transformation. As this occurs psychodynamic theory points to the importance for managers on behalf of both staff and users of paying attention to the appropriate maintenance of boundaries and the qualities of the bounded 'space'. The 'shopping list' approach to provider development is therefore at odds with the approach being described here.

3.25. In short we suggest that managers might ask themselves;

- what service structures should be maintained, and how much (defensive) energy is going in to maintaining these structures?

- and are the pressures for change identifiable in terms of their contribution to likely improvement if the existing structures were liable to break down?

Here we see the interplay between three key components of management as leadership - the ability to identify what needs to be maintained; the performance of what are agreed necessary structures; and the creativity and innovation which can result by analysing (and sometimes loosening or not maintaining) the 'boundary' conditions of structures.

3.26. It is difficult to allow this form of evolution if the organisation's core clinical functions are defensive and risk adverse because of fear of bad publicity. Defensive routines under which rubric some would also include paper led conformance systems such as CPA, may lower anxiety in some quarters but may lead to a cycle of energy-sapping maintenance of old structures, roles, and boundaries, block growth and evolution, and limit organisational flexibility.

If managers wished to allow the 'CMHT' function, for example, to evolve and adapt, (and potentially differently in different sectors) they would probably want to know more about its characteristics.

3.27. The idea of "inner space" has been used to point to the qualities that may exist within such a team boundary. This can be expressed as a figure as in diagram 2.

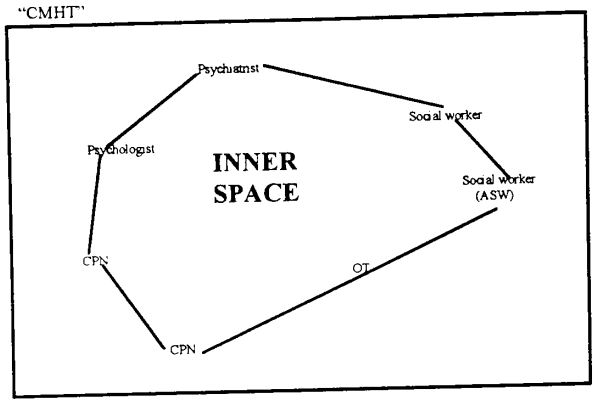


Diagram 2

3.28. There are 'push' and 'pull' factors which determine the extent to which such "CMHT" type groups of professionals can optimise their effectiveness. These are:

- the clarity of the team's primary task
- the accountability to the team by individual members
- the sense and source of value and identity of team members
- the allegiances of team members
- the existence of leadership
- the variety of explicitly authorised activity

3.29. The creation of the safe "inner space" as the context for care is determined by these factors, as is the creation of a clear "boundary". When these features became clearly defined then we are dealing with an organisation as an entity as a 'whole' and not just as a part or as the aggregate of the members. As an entity the "CMHT" can now interact with the other bounded entities in its field of forces. If senior managers focus strategically on this "relational space" then they may consider that the functions of the whole organisation may be developed by enhancing the ability of the "CMHT" to act as an organisation itself. The challenge here is to design information, data systems, technology, business planning and management systems into the structure of the

"CMHT". This gets leadership and decision making closer to the variables which create uncertainty at a "strategic" level.

The enhanced, autonomous and adapted "CMHT" may have the team composition as set out in diagram 3.

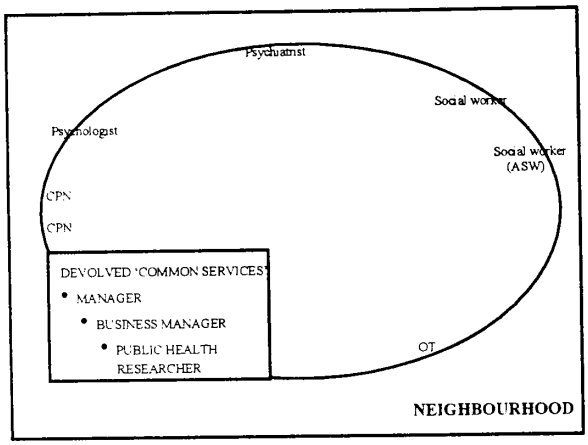


Diagram 3

3.30. The previous sub-system "CMHT" is now a bounded entity and an organisation capable of designing a service to a neighbourhood. Its boundaries and transactions are determined by a developed membership with the capacity to process information, gather data, enter into negotiations, business plan and other features. In short it can be more adaptive.

3.31. If the "CMHT" because of its enhanced membership and delegated authority possesses

- the ability to process epidemiological needs based data and link it with case mix and activity levels
- the ability to develop a business plan, manage costs and purchase services
- managerial leadership as a complement to clinical leadership

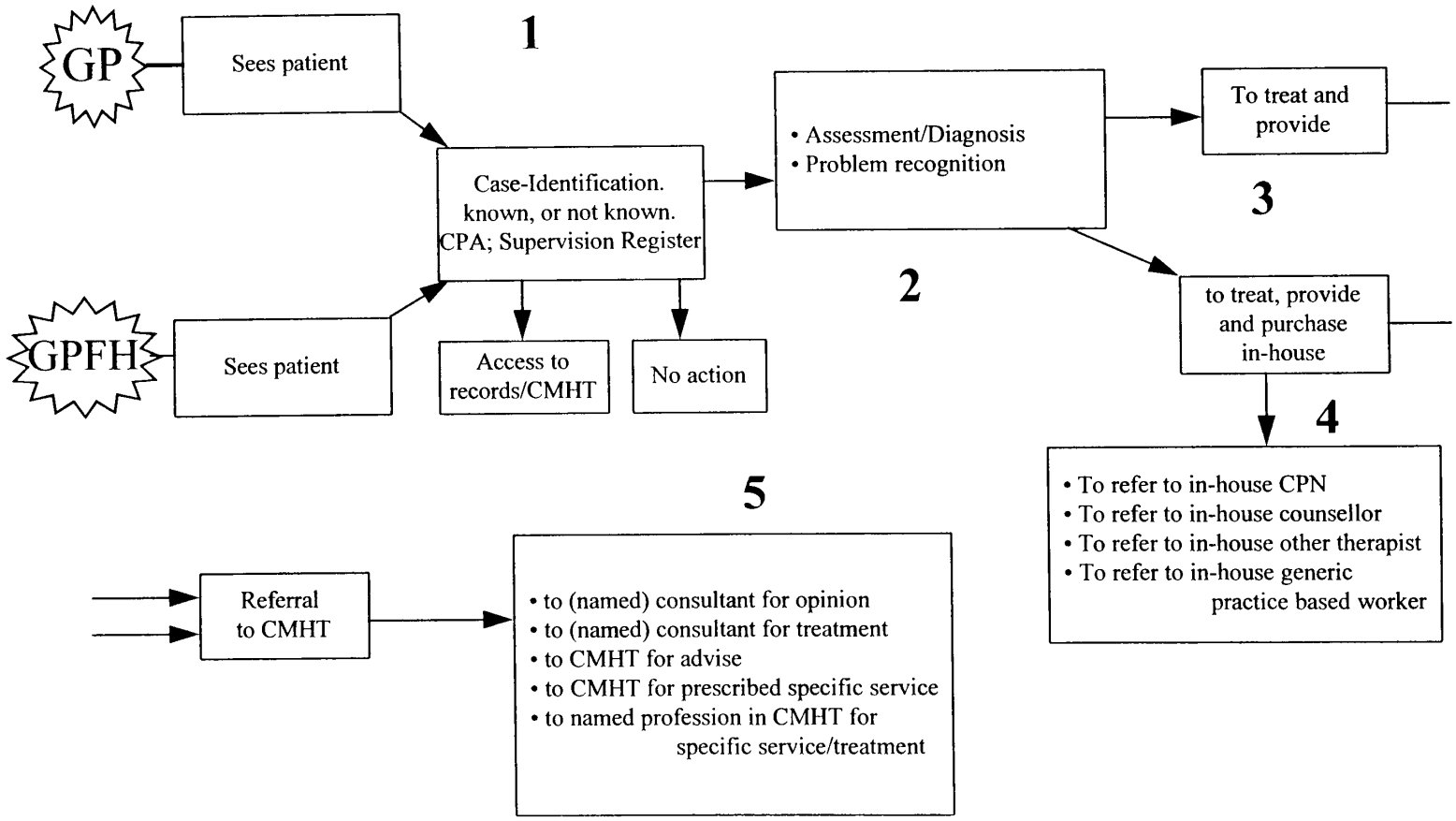
then the interaction with its environment will begin to show new patterns of activity. This devolution will increase diversity in the organisation and allow for varieties of service responses as appropriate in different sectors and neighbourhoods. It will also enable a reduction in some central services by creating local self-management. This may seem at first glance to be simply an argument in favour of delegation and structural decentralisation. It is, but more, the concepts of 'boundary' and 'space' enable managers to chose a focus for understanding adaptation, maintenance and risk management. The positive feedback data can be generated by the creation of the "CMHT" as an organisation rather than a sub-system thereby, giving it the capacity to adapt to its environment, and the trust the ability to discriminate between the feedback signals as the "CMHT" adapts.

3.32. We have now drawn a picture of the "CMHTs" type function and organisation. In adapting to its environment it will have to take account of how other sub-systems, or parts of the wide system will interact with it. On the one hand the relationship between the "CMHT" and secondary case in particular the acute beds/wards will be of importance. On the other hand however a key interface, and one which is a major factor in creating and maintaining a "system pathology", is the boundary between the "CMHT" and Primary Care and the nature of the transactions between them. There have been attempts to manage, cross, dissolve or ignore this boundary (see paper by Edward Peck, CMHSD) and some have been more successful than others. What may be at stake in the management or otherwise of the boundary is the "capture" of activity and resources now located in secondary care, by primary care, which entails the empowerment of an alternative group of medical practitioners and a re-assessment of patient needs which have tended to be defined by their location; the "seriously mentally ill" predominantly in the "CMHT" arena, and the "neurotic" patients in primary care. How then might we understand better the way in which primary care teams and in particular GPs will relate to the part of the service system which as a function and sub-system we have tagged on "CMHT"?

3.33. We can begin by considering how the two sub-systems communicate. The following diagram sets out 5 critical points in a communication and referral process between primary care and "CMHTs". The analysis of these issues is not intended to be the

basis for such a solution as a protocol, my point is quite different, the illustration is intended to focus attention on the possible dysfunction created between two sub-systems because they remain sub-systems. The question of a new emergent service structure which dissolves the boundary could be considered as a development.

REFERRAL RELATIONSHIPS BETWEEN GP/GPFH AND CMHTs



3.34. This illustration has been part of a bigger exploration of the approach managers in particular, but also clinicians might take to the component parts of a mental health service.

3.35. So in summary, to try to provide some thoughts towards defining some of the management challenges, a checklist might be:

- of the sub-systems I have inherited or created in my organisation which could be developed into organisations? Can I devolve functions to them to make them self-managed, locally responsive and adaptive?

- are these sub-systems and emerging entities well bounded or not; can I understand the positive and negative forces internally and externally which create these conditions?

- Can I, by managing in the "relational space" between bounded entities that I deem necessary, assist them in their relationships?

- Can I notice the positive feedback data, sift it and shape an emergent strategy as patterns emerge?

- Can I re-establish new boundaries, the primary task, roles and functions of new organisations in order to create the appropriate qualities in the "inner space" and in the relational 'space'?

3.36. Using these related concepts of "space", "boundary" and "transition" enables managers to confront the structural inheritance of their organisations and ask questions about the necessity of certain bounded structures. We have suggested that looking at the inner and outer qualities of these bounded "spaces", the roles and energies used by people to maintain degrees of rigidity and flexibility, plus the appropriateness and ease with which transitions are made across boundaries will provide a useful critical stance. It will provide data on the adaptive effectiveness of the structures.

3.37. We have given an example of a specific "CMHT" type structure, but how do these concepts help managers think about a mental health service as a whole system?

3.38. It is possible to conceive of a whole service as a 'map' of four domains, 8 "spaces" with four key boundaries. In the following diagram two dimensions of a local mental health service - the "wellness/unwellness" of its users who are "in the service" or "not receiving a service" enable us to establish four domains A,B,C,D. This provides a straightforward figure

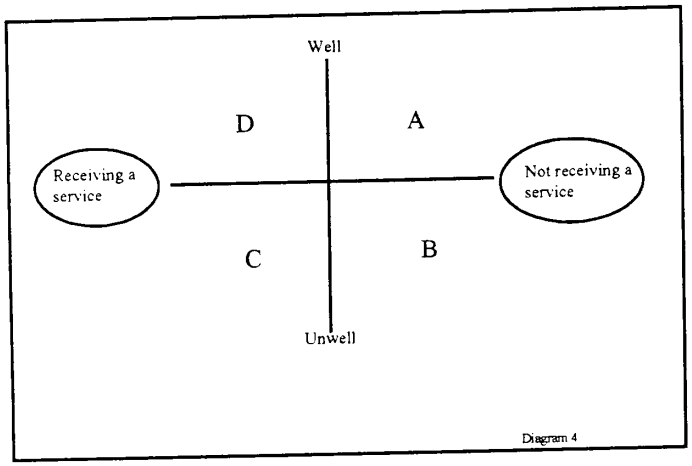


Diagram 4

3.39. There are some focii in each quadrant which are central to a strategy of discovery by managers. However before specifying some of these let us add to the concept of boundary that of "transition". Traditionally the transitions made by patients were determined by the boundaries of services structures. What kinds of service structures would emerge if they were made dependent or contingent upon the transitions that 'users' make in becoming unwell, using or not using the service, progressing to wellness and to independence from the service or to some other relatedness to it? The diagram therefore points to four boundaries around which cluster a number of current service structures. The 'boundaries', transitions and spaces can be mapped on the figure as follows, this gives us 8 "spaces":

diagram therefore points to four boundaries around which cluster a number of current service structures. The 'boundaries', transitions and spaces can be mapped on the figure as follows, this gives us 8 "spaces":

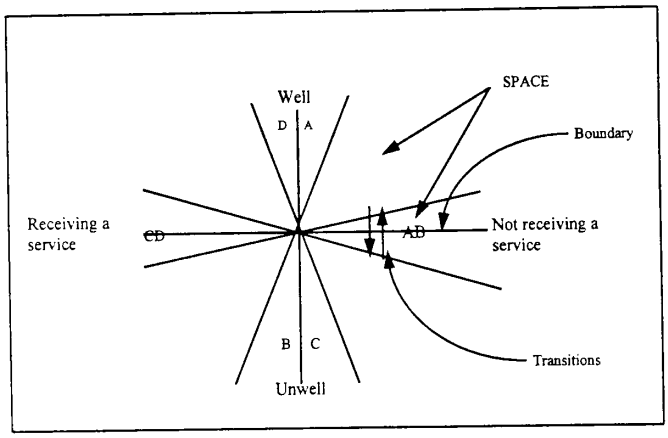


Diagram 5

3.40. For example the AB 'boundary' speaks to critical moments of crisis, insidious deterioration, fluctuations in coping, onset, relapse and many other descriptions of the process from wellness to unwellness. What kind of characteristics in 'space' A influence the transitional process at 'boundary' AB, and what 'boundary' conditions might exist?

3.41. If these characteristics of 'space' A include for example

- alert systems
- crisis card-carrying
- telephone hot lines/advice
- walk-in facilities
- public education
- support to carers
- data on help seeking patterns
- self-referral systems

- support to non-mental health agencies

then there may be both a preventive and responsive quality in that 'space'. This is also a domain in which epidemiological data, prevalence and incidence studies can be useful. The characteristic of the service elements and other structures in 'space' A determine, by their boundaries, the experiences of both the inner world of staff roles and the dynamics of engagement with the prospective users. The concept of the 'boundary' is important because it links the conditions which exist for crossing the 'boundary' (input or output and the experience of the 'user') with the characteristics of the inner 'space' of the bounded structure as created by the playing out of the staff roles within it. These roles critically include those of leader and other authority issues.

3.42. A focus on 'space' A and 'boundary' AB invites managers to consider what and how they want to

- maintain
- improve performance in existing structures
- innovate and change

within a 'space' in which a population has mental health needs and where the transition into unwellness and engagement with the service is critical and these take place at the 'boundary' of the local service structures.

3.43. Consideration of this and other quadrants in the model should prompt an understanding of, and therefore a managed response to the things that matter in coping with mental health problems in ordinary life. For example at the point of 'discharge' at the boundary CD 3 simple questions can help summarise the enterprise, of "community care", which from a citizens perspective can be expressed as:

- do I have a secure and private place to live?
- do I have some activity to during the day which is worthwhile for me?

- do I have supportive relationships and contacts that can help me get the assistance and if necessary, treatment that I might need when and how I need it?

If managers constantly asked those 'outcome' questions of their services it would throw into relief for further examination, structures, roles and activities which did not contribute to these ends.

3.44. Space here does not permit a detailed analysis of all the possible characteristics of the 8 "spaces" and 4 boundaries in the model. The value of this model is to 'map' existing activity within a conceptual framework which allows significant changes and adaptations in existing structures to be conceived without being drawn into the detail of existing structures and their current rationale.

3.45. The proposition which I am putting forward here is as follows. The complexity of mental health services is increased by the existence of a wide range of theoretical models. Clinical leadership has been linked to a particular model and as its limitations are discovered the role of clinicians as leaders becomes difficult to develop and sustain. This makes effective team working in the community difficult at the level of role, complex at the underlying level of theory and short on organisational capacity. The "CMHT" type structure as an example displays these dilemmas. The concepts

- primary task
- role
- leadership
- authorisation
- 'space' ('inner space'; 'related space')
- 'boundary'
- transition
- feedback (positive and negative)
- adaptation
- 'bounded instability'

can help managers in focusing on the structures in their mental health services. These concepts relate to our understanding of 'open systems' and how they interact with their environment. The variety of 'boundary' conditions in relation to inputs; task; role; time; and transitions are open to more detailed analysis in the field by both teams and managers. The diagram 5 suggests a way of using these concepts about the whole system, and identifies 8 'space's and 4 key 'boundary' areas where managers using these concepts can select an appropriate balance in their leadership of maintenance, performance, innovation and change. Managing in the "spaces" both "relational" and "inner" in the structures; managing adaptation by allowing diversity and attending to the constant creation of tasks, roles and boundaries; listening to the signals that come from the transitions at the boundaries, may equip managers with an approach which can enable them to cope better, and creatively, with uncertainty and complexity.

4. CASE STUDY: ILLUSTRATION OF ORGANISATIONAL CONSULTING TO A MENTAL HEALTH TRUST** (Not for quotation without authors permission)

4.1. This case study is intended to illustrate some interventions which can be made in mental health organisations in the light of the conceptual framework set out above. The case study is written from the perspective of the consulting practitioner.

4.2. The intended focus of the consultancy.

In this Trust I was contracted by the Board and CEO . My accountability was to the CEO. The main focuses were:

a) The strategic direction of the Trust's mental health functions.

b) The relationships between the mental health Directorate and HQ functions and personnel.

c) The inter-disciplinary issues between professional groups.

d) The feasibility and impact of introducing Integrated Care Pathway methods into the acute wards in the central hospital.

e) To support the CEO in working on the practical management of Executive and Non-Executive Directors

4.3. This contract illustrates a number of features of practice. Firstly, it seems important to work with organisations for a year or more after an initial 3 or 4 months mutual trial period cut-off. Initial contracts and specifications conceal as much as they usefully specify and the nature of the consulting role emerges during the work. Understanding the tension between a specified tender and contract and keeping the work "emergent" but under review is critical to the consultant's relationship with the client. I worked with the CEO using regular written "working notes" and regular personal sessions on his own role and part in the organisation's development. The Medical Director of the Trust was centrally involved in the work and as the Clinical Director of the mental health directorate, he occupied a number of roles in the organisation (clinician, manager, Board Executive). Central to the work was the management of the tensions between these roles, and the relationship between the CEO and the Medical Director. In particular, issues of who was the client and matters of confidentiality and reporting were constantly in play, and provided important data for the protagonists in their evolving relationship. I note this to make the point that the nature of the consultant in a "change agent" relationship to the central actors is a key source of learning for the organisation and "simple" issues such as "who is the client" are not usefully dispensed with by an initial contractual definition. In this case, it became clear that enabling two key people to talk to each other about their respective roles and attitudes was an important focus of the work.

4.4. In these kind of contracts, I expect to work at a number of levels of the organisation simultaneously. I sub-contracted a number of surveys of activity and audited some practice; I engaged with the Directorate Team and observed their meetings; I explored with managers and clinicians and with front line nurses how the problems in

the 3 acute wards could be thought about and addressed; I interviewed all the Board executives using a Cognitive Mapping approach and then held a series of meetings with them; I do not however think of this process as "diagnostic"; I prefer to see my role as an adaptive agent, providing a focus for thinking and feeling; creating spaces, places and times within which people occupying various roles can explore what they mean by the notion of a "strategy", "objectives" or "outcomes". The overall sense is of an emergent change process whereby a range of types of change may happen simultaneously and challenge those working in the organisation to manage their tendencies to control or not control events; to manage fear and anxiety; to reflect upon their role and identity and its source in relation to the "primary task" of the organisation.

4.5. During this work I have had in mind a number of theoretical perspectives pertaining to various parts of this work:

4.5.1. at the level of "strategy" I have been influenced by Mintzberg's ideas and used these as a framework for the sessions with the Executives;

4.5.2. the apparent need to work at various levels of the organisation simultaneously in the context of a trust-wide concern with "strategic direction" was influenced by the framework of Klein and Eason and their review of the literature on interventions at the:

- personal level (core identity and value)
- the roles and relationships
- the context and culture ("situations") in which these roles are played out
- the structural "givens" within the organisation;

4.5.3. the access to people's stories and "scripts" about the organisation was influenced by my use of Bougon's approach to "Cognitive Mapping" which is

a non-directive and inductive method for opening up some narrative material and sharing it with others;

4.5.4. the idea that the organisation "had to change" was helpfully examined with key players in the light of Blackler's framework of changes which are incremental (calling upon features of continuity and improved performance of existing practice); changes which are less clearly "linear" and which are rapid transitions towards partially known destinations (calling upon features of leadership, vision and values); and changes which have long-term uncertainty and may re-define the ontological basis of the organisation (calling upon features of creativity, entrepreneurship and continuous innovation and adaptability). I used these ideas with the CEO and Medical Director in order to clarify what kinds of challenges would be presented to their staff by each kind of change in the knowledge that all three types were happening in the organisation and promoted by them;

4.5.5. the systemic nature of complexity created by the inter-relationships between individuals, groups and the organisation I find helpfully clarified by the work of a number of writers and practitioners who might broadly be referred to as "psychodynamic" in their thinking. The seminal work of Miller and Rice and Menzies Leith have been important in my practice development. The "defensive" nature of much activity in mental health organisations has also been commented on by Hinchelwood. The psychodynamic concepts of projection; transference, counter-transference, and unconscious processes is central to my thinking about what is happening within the organisation and in my relation with "it" and its key actors and others;

4.5.6. the nature of "learning" in organisations seems to me to be related to the way in which change and development take place or do not occur. I find the distinctions between knowledge (from personal knowing and from empirical enquiry), learning as a shared enterprise of active exchange and modification in the search for meaning) and creativity (the imaginative energy which

sustains and creates new possibilities) useful in designing interventions. This enables me to be clearer, I think, about the notion of progress and development itself and how and where this will or can take place, in what mode of change (Blackler) and at what levels of the organisation (Klein and Eason).

4.6. So what did I actually "do" on site over a period of 18 months and with what results?

This can probably be expressed as a figure since it was taking place simultaneously. There are 8 domains represented in the figure attached.

Consulting to a Mental Health Trust: Simultaneous Domains of Activity

Work with CEO

"Mentoring" relationship with the CEO; his own career, his problems with non-executive directors.

Reporting relationship to the CEO and examination of his HQ role in relation to the directorate and his relationship with the Medical Director/Clinical Director.

Work with Medical Director

Personal consultation with the Medical Director in his role as Clinical Director. Examining his powerful and confusing tendency to violate his role(s) and be confused between them.

He was at any one time:

contract negotiating with GP fundholders and innovating at the margins of the organisation "entrepreneurial role";

managing the directorate team by a collusive relationship with a "tough" nurse manager (male) and closing out the female members of the team "management role"

being absent from the Trust on national R&D or HAS business and "fire-fighting" crises on his return "the national expert role"

being the Medical Director but using his position to benefit his own directorate "political role".

This work was ongoing since the person concerned continued to deny the role violations. but when he became aware of them continued to use the repertoire to avoid clear accountability to the CEO.

Work with both CEO & Medical Director

Work with CEO and Medical Director together on the "task" of sectorisation; creation of "self-managing" community teams; liaison with GPs and the disaggregation of acute beds to sectors.

- 5 papers produced.

Sector Team

Work with a sector team on the impact of new "home-treatment" models and the new relationship with the acute wards. (in-house consultant appointed)

Acute Wards

Work with the 3 acute wards - all nursing staff, all grades, on designing an Integrated Care Pathway for different patients. Using outside experts on the technology and working on major issues of morale, identity, purpose and clinical-clinical (nurse-doctor) and clinical-managerial relation-ships which were tense and distrustful.

Executives

Work with other Executives feeding in survey data to assist in a focus on strategic direction.

Directorate

Attending Directorate meetings and observing their process. Using observational data gathered during their sessions to open up an issue of power "pairing" and gender issues which diverted energies from the primary purpose of supporting and enabling staff within the context of a sound business plan. The aggressive managerial styles of middle managers continued to be a focus of concern.

The results of the consultancy to date are:

4.6.1. early input of data from sub-contracted audit showed poor performance against national standards and created conditions which both increased receptivity to changes and set up some defensive postures;

4.6.2. the CEO and Medical Director were able to confront their relationship problem and improved role clarity enabled them to ask things of each other and recognise their complementarity. They were also able to have conflict with each other and work with their material, their opinions and feelings about the other;

4.6.3. the acute ward staff nurses over 18 sessions worked at genuinely "authorising" their clinical nurse managers. They in turn have emerged as strong enablers of staff; better able to help staff cope with the challenges of psychosis and disorder; and able to define boundaries with "aggressive" male middle managers and work at negotiating resources;

4.6.4. the acute ward staff successfully designed 3 "integrated patient pathways" which enabled a clearer definition of their interventions and their responsibilities to patients;

4.6.5. the shape of the Trust's own structures were changed - from 5 sectors into 4 to make them coterminous with primary care; the home-treatment sector was supported in its work by the CEO and the plans for local management of acute beds; sector budgeting; self management of sector teams, was significantly advanced, and is still ongoing;

4.6.6. the posturing entrepreneurship of the Medical Director ceased and he became more "realistic" in what he expected when he gave up his illusory "maverick" role and concentrated on enabling existing staff to make progress at their appropriate pace. He relaxed significantly as he learned enabling skills which helped him act through others and with them.

4.6.7. the CEO recognised that he was not happy in his job and found that as the Clinical Director developed his role, that he became less tied to the problem of the mental health directorate.

4.7. I hope this case study has provided an example of consulting practice in mental health and some links between theory, practice and on-site "outcomes". There are some general points on the role of consultant and my sense of it which might be relevant to our understanding of change processes in mental health organisations.

THE ROLE OF THE CONSULTANT

4.8. As a consultant, I am working with my own awareness, insight and both conscious and unconscious knowledge of the people, relationships, roles, events and responses as they go on around me and when they directly involve me. This partial and sometimes fragmentary grasp of the realities for those working in the organisation is however the base "data" which I can make use of in responding and making interventions in the continued unfolding of the organisation's life. There are some interventions that derive from what I know of mental health services, some which derive from the key actors' meanings and intentions. My main aim is clarification, description preceding prescription, the bringing into conscious awareness of feelings, attitudes and behaviours which trap and disempower staff. More positively, I am asking questions to the staff about autonomy, about taking up a role and its attendant responsibilities and increase knowledge of the inter-relational consequences of moving forward with purposes, reasons and intentions as an agent, rather than seeing oneself as "managed", "manipulated" or simply as a "cog" or a victim of circumstance. How I am treated, how staff treat each other and the norms and culture that is thereby accrued provides pointers to how fully human people can be in the particular workplace.

4.9. I am convinced by the insights of Menzies Leith and by Hirschorn that familial roles are often (re) dramatised in the workplace. The range of "psychoanalytic" concepts - splitting; projection; boundary management; role clarity; defensive postures; "pairing"; denial; blame; I find valuable in my thinking as I work. I am not however engaged in the creation of a psychoanalytic discourse as a consultant. I eschew the use

of psychoanalytic terminology unless there is no simple way to say or elucidate a particular set of circumstances. Making material available through staffs' descriptions/narratives/scripts/stories/myths is often the best focus of effort. The interpretative stance is often unhelpful in relation to this material if it takes the form of "naming" of feelings, attitudes and processes which, when perceived in a purely cognitive mode, prevent learning taking place. Learning by experiencing these phenomenon, for example, becoming aware of holding untested beliefs about others (and projecting them), is not best understood by pointing to the process but by enabling staff to talk to each other in situations designed to make available the clearer realities and qualities of others.

4.10. This case study illustrates the complexity of trying to achieve change within a mental health provider organisation. The necessarily fragmented mature of engagement, process and change is clear. The activity does fit the 3 way distinction made by Blackler in the following way.

Incremental change

- The Trust improved their ward based practice in acute wards.
- Relationships between the Directorate and HQ improved.

Rapid Transition

- The re-sectorisation and development of Home Treatment and potential disaggregation of beds was moved forward.

Uncertainty and Innovation

- GP fundholders' intentions were recognised as potentially destabilising and required creative responses.

The process of change is faltering and messy and illustrates the tension and allocation of effort between remedial change activities and creative change activities.

5. FOLLOW UP ACTIVITY IN THE FIELD FOLLOWING THE SUPPORT GROUP REPORT AND IN THE CONTEXT OF THE GREEN PAPER

5.1. In the follow up activity on development sites to take forward issues raised by the London Commission Report, careful thought will need to be given to the focus of effort around these kinds of change envisaged. A set of interventions will need to be designed which can encourage the capacities of staff in their use of knowledge (data), their ability to learn together, and their willingness to tolerate uncertainty in the context of creativity and innovation. There are some broad elements of such a development strategy based on the conceptual framework developed above (Klein and Blackler) and informed by an awareness of the nature of "system pathologies". These elements are:

5.2. We should encourage managers and commissioners and all who work in and use the service to think radically about the system, the primary tasks of the component parts and the ontological basis, rationale and apparent "necessity" of the sub-parts of the organisation. This will take neighbourhood, community and locality seriously as the basis for a mental health services.

5.3. We should be working with both theoretical and practical models of what has been used in other areas, and countries.

5.4. We should develop a 'vision' with key players, based on sound principles for how a service ought to be, and begin to consider the kinds and types of changes required.

5.5. We should define the kinds of interventions which assist the different features of "learning" in collaborating learning organisations. We should design interventions, processes, engagement and high participation by users, public and staff in the

approaches to learning, adaptation and behavioural change set out in the framework above

5.6. We should help set the system and its resources "free" to reconfigure itself and create new (transitional) processes and structures consistent with the ideas that have been generated. We should attend critically to issues of empowerment and responsibility.

5.7. We should assist in "Flooding" the system with relevant information and feedback and ensure that an "R&D" action-research methodology is in place such that the evolving service system can "speak to itself" and see a "mirror" of its process and progress.

5.8. We now turn to the application of our analysis in the field and the specification of

5.8.1. The arrangements and conditions under which significant exploration and development can take place.

5.8.2. The kinds of change and development interventions which might be developed with local actors by external agencies e.g. King's Fund, CMHSD.

5.8.3. The kinds of activity which might be being considered developmental by the local service.

5.9. The case study example given shows the limitations of a single consultant attempting to undertake a range of different types of interventions and project manage others. If we are to make any significant impact in this field we require a **balanced team** which can offer a **range of interventions**. There are several key elements to such a team intervention.

5.9.1. The ability of those making change interventions to spread activity across a long enough time scale to have an impact; in this case a minimum of 2 years will be required.

5.9.2. Ability to project manage a programme of work which will balance sub-contracted expertise with continuous process consultation which will "contain" and support the activities of the programme of work.

5.9.3. The ability to work at all levels and interfaces of a complex system simultaneously.

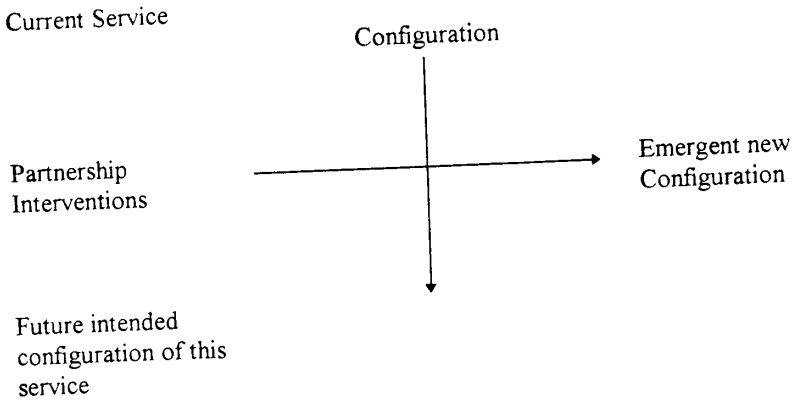
5.9.4. The prior commitment of local agencies to engage in this process. These initial contacts should embody the experiential and committed approach required by all the agencies.

5.9.5. Clarity on funding and support from Regional Office. Discussion of "matching" funding with King's Fund.

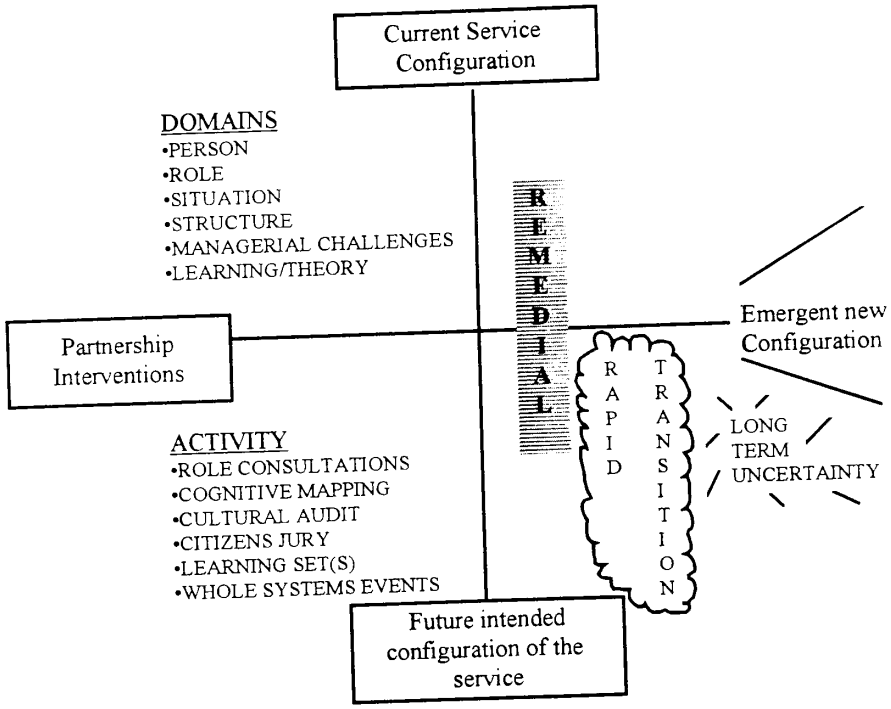
5.10. We now turn to the relationship between

- the inherited configuration of a local service;
- the local strategy and intentions;
- the interventions which we might make in partnership with the service;
- and the emergent new configuration of activity.

We can think of this set of relationships **so that we neither assume that change can take place against a blank sheet (a re-engineering; zero budgeting exercise), or that any of the current configurations or strategy is inevitable (accepting a "false necessity")**. The stance proposed is that in the framework set out earlier in this paper (see Diagram 3 para 2.18). The relationships can be thought of in the following way;



5.11. We can now bring the local intervention activity in the above diagram into the earlier framework, this shows the levels at which interventions have to be made and the kinds of change envisaged;



5.12. In more detail we can map onto our framework the kinds of activity which services currently consider as developmental. The interventions that we might make in these services need to be informed by history; current conditions; current developmental ideas/strategy but it is essential in process terms that our interventions are neither remedial or developmental in being wholly driven in content by the local agenda. This will "trap" the intervention strategy into a diagnostic approach, or an implementation approach or both. The theoretical and practical proposal in this paper is based on a development programme **driven by a commitment to a re-examination of the nature of the enterprise from perspectives of the client/user; the nature of helping relationships; and the identity and role of those who work in this service**. This makes what emerges contingent upon the process of renewal and transformation. The key to his approach is the search for meaning, intelligibility, identity/role, within three kinds of development modes - a) the use of current empirical data/evidence (KNOWLEDGE); b)the capacity to learn, explore, engage collectively in shared learning across boundaries of agency and discipline (LEARNING, UNLEARNING, COLLECTIVELY); c)the capacity to unlock creative and imaginative ideas and responses to need and to tolerate risk and uncertainty by relating sensitively to the environment. (CREATIVITY; RESPONSIVENESS, REFLEXIVITY).

5.13. These development modes are complementary and making them so will be major focus of our work. The ability of persons, departments, agencies to recognise which mode is appropriate in what circumstances and what the consequences will be of adopting it, is a key area of skills development.

5.14. What kinds of interventions (what I have called partnership interventions) might we adopt in this field? The following diagram sets out 14 types of interventions within the theoretical framework adopted in this paper. These are as follows:

1. Preparation for change events
2. Learning Sets Uni-disciplinary/Multi-Disciplinary
3. New Teams
4. Intergroup/Interagency Events

5. Citizens Jury
6. Evidence Based Data Access
7. Common Ground Event
8. Models of Care
9. Inter-Agency Concordats
10. Green Paper Consultations
11. Data Flow/R&D Audit-Reflexive Systems
12. Whole Systems Event
13. Futures Event
14. Group Relations Type Programme
15. Quality of Life Measure

Please refer to the diagram where these are 'mapped' on to the conceptual framework.

EXAMPLES OF PARTNERSHIP INTERVENTIONS PROPOSED AS A LOCAL PILOT/ DEVELOPMENT SITE FOLLOWING THE KINGS FUND LONDON COMMISSION REPORT.

Development Levels ▼	Types of Change ▼ Remedial/Incremental	Rapid Transition	Long-Term Uncertainty
Person Role/Relationships Situations Structures	1 PREPARATION FOR CHANGE • ROLE CONSULTATIONS. • MYERS-BRIGGS • COGNITIVE MAPPING. 5 CITIZENS JURY 6 EVIDENCE BASED DATA ACCESS 7 COMMON GROUND EVENT MODELS OF CARE 8	2 LEARNING SETS UNI-DISCIPLINARY/MULTI-DISC. 3 NEW TEAMS INTERGROUP 4 INTERAGENCY EVENTS. 9 INTER AGENCY CONCORDAT 10 GREEN PAPER CONSULTATIONS	14 GROUP RELATIONS TYPE PROGRAMME 13 FUTURES EVENT 15 12 WHOLE SYSTEMS EVENT/ QUALITY OF LIFE MEASURE 11 DATA FLOW/ R+D/ AUDIT-REFLEXIVE SYSTEMS
Managerial Challenges ➡	• Problem solving • Managing Continuity • Improving Performance	• Competition • Re-direction • Disjunction • Vision	• Responsibility • Values/Beliefs • Leadership • Innovation
Personal/TEAM/ORG'L Development ➡ LEARNING MODES.	• Use of Knowledge • Existing Criteria • SHARPENING THE FOCUS • "SWEATING THE ASSETS"	• Unlearning • Re-framing • New Criteria	• Collective learning and creativity • Imaginative responsiveness

5.15. What kinds of activity do mental health services currently consider to be developmental? How might we 'map' these concerns onto the model? I have been fairly general in these descriptions, however in any (pilot) site envisaged for partnership in this programme a high level of detail will be possible.

The selected examples of local developments are as follows:

1. - Multi-skilling
   - Investors in people
   - Defining competencies
   - Quantitative data driven activity levels

2. - Team Building/CMHTS
   - Making CPA work
   - GP/PHC liaison

3. - Locality/Sector Focus
   - Protocols/ Integrated Care/Pathways/Standards/Conformance
   - Managing the Health/Social Care divide
   - Reducing Beds/Attempting to create a "spectrum of care"

4. - Recognition of problems of morale/retention of clinical staff.
   - Risk adverse behaviour
   - Managing Public Scrutiny
   - Managing Inertia

5. - Search for Clinical Leaders
   - Search for new roles and collaboration

6. - Commissioning acute beds from sectors
   - Home treatment
   - Crisis services
   - Outreach teams
   - Primary Care Liaison

7. - Re-sectorise
   - capital spend for CMHT type functions

8. - What can unlock the current professional rigidities?
   - What are the sources of belief/commitment/energy and how can we unlock them?

9. - What shared responsibilities are possible?
   - What helping roles do we see for staff?

10. - Can we produce more flexible and responsive services?
    - Can we do this by empowering staff and making decisions data-driven?

11. - Green Paper: ? Can structure follow function or are we reorganising the furniture?

These can also be 'mapped' on to our framework in the following diagram:

SELECTED EXAMPLES OF ACTIVITY WHICH MENTAL HEALTH SERVICES CONSIDER DEVELOPMENTAL.

Development Levels ▼	Types of Change ▼ Remedial/Incremental	Rapid Transition	Long-Term Uncertainty
Person	1 • MULTI-SKILLING/ • INVESTORS IN PEOPLE/ • DEFINING COMPETENCIES/ • QUANTITATIVE DATA DRIVEN ACTIVITY LEVELS	4 RECOGNITION OF PROBS OF MORALE/+ RETENTION OF CLINICAL STAFF. RISK-ADVERSE/ PUBLIC SCRUTINY/ INERTIA	8 WHAT CAN UNLOCK THE CURRENT PROF. RIDGITIES? WHAT ARE THE SOURCES OF BELIEF/COMMITTMENT/ENERGY AND HOW CAN WE UNLOCK THEM?
Role/Relationships	2 • TEAM BUILDING/CMHTS/ • MAKING CPA WORK/ • GP/PHC LIAISON.	5 SEARCH FOR CLINICAL LEADERS. SEARCH FOR NEW ROLES + COLLABORATION.	9 WHAT SHARED RESPONSIBILITIES ARE POSSIBLE? WHAT HELPING ROLES DO WE SEE FOR STAFF?
Situations	3 • LOCALITY/SECTOR FOCUS • PROTOCOLS/INTEGRATED CARE PATHWAYS/ STANDARDS/ CONFORMANCE	6 COMMISSING ACUTE BEDS FROM SECTORS HOME TREATMENT CRISIS/ OUTREACH TEAMS/ PRIM CARE LIAISON	10 CAN WE PRODUCE MORE FLEXIBLE AND RESPONSIVE SERVICES? CAN WE DO THIS BY EMPOWERING STAFF AND MAKING DECISIONS DATA-DRIVEN
Structures	• MANAGING THE HEALTH/SOCIAL CARE DEVISE • REDUCING BEDS/ATTEMPTING TO CREATE A "SPECTRUM OF CARE	7 RE-SECTORIZE CAPITAL SPEND FOR MENTAL TYPE FUNCTION/	11 GREEN PAPER: ? CAN STRUCTURE FOLLOW FUNCTION OR ARE WE REORGANISING THE FURNITURE?
Managerial Challenges ➡	• Problem solving • Managing Continuity • Improving Performance	• Competition • Re-direction • Disjunction • Vision	• Responsibility • Values/Beliefs • Leadership • Innovation
Personal/TEAM/ORG'L. Development ➡	• Use of Knowledge • Existing Criteria	• Unlearning • Re-framing • New Criteria	• Collective learning and creativity • Imaginative responsiveness

5.16. In this section I have tried to show how the conceptual framework for understanding different kinds of change, at different levels in an organisation and which call upon different cognitive learning modes which shape staff behaviour is robust. Robust enough to be the basis for a significant dialogue with key players in the field.

6. TRANSFORMATIONAL PROCESSES

6.1. If the description and explanation of the conceptual framework for change (diagram 3) is robust we can move on to consider what sources we would use to help a mental health organisations consider the nature of the most complex kind of change; that characterised by continuous uncertainty but high levels of innovation and creativity (column 3 right). We might also ask what features tend to **sustain** such change, since we are familiar with the following pattern of description;

- product champions moving on elsewhere
- burn-out and "founders syndrome"
- "projectitis" and the problems of generalising findings from specific pilots or initiatives.

6.2. We begin this short exploration of the sources and character of transformational processes with a paradox. Mental Health organisations are primarily concerned with matters "mental". We do not wish to be side-tracked into the "mind-brain" debate except to note that issues of will (volition); affect (feeling/emotion); and reality testing are precisely at stake in the therapeutic work of these organisations. It is therefore unsurprising that in intervening in disturbed mental processes those who work in the organisation may tend to find a static normative backdrop to their work helpful and important. If this can not be determined in the cultural context it can be attempted within the specific organisation.

6.3. The recent study by the Fund (Edward Peck's work with managers) and the same author's article in the Guardian (29 January 1997) report that managers are desperate

for a period of stability and do not want further major changes. Morale is low amongst psychiatrists who often take early retirement or move into the private sector. The paradox resides in the necessarily transformative mental processes involved in helping relationships within these organisations and the "false necessity" accorded to the organisational aspects, structures which are the containing function of the organisation. These organisations may also grow to need the myth of "the community" to which they return their patients, or to which their patients retun.

6.4. In order to alert ourselves to the possibilities of transformative proceses we might consider our of a series of propositions about the construction of social reality;

- Meanings are socially created
- What I/we do is what may be and become possible
- 'need' is constantly being redefined
- the living of lives, ordinary life is the enterprise not living out the inexorable consequences on disorder
- personal growth, development, becoming do not stop in the transformation process from the deepest psychosis at some defined point of being "symptom-free", "able to cope", "ready for discharge" or any other arbitrary point or boundary, we have to explore with them a continuum of coping and development.
- We are faced with choices as prop between paternalism, partnership, managerialistic or separation for the future **organising** of the enterprise of living with and after mental disorder

- There is a connection between their individual forces of coping and recovery (sometimes life-long vulnerability) and social justice and citizenship.

6.5. How do mental health organisations engage with and respond to these issues? The debate will focus on the nature of the helping relationships with them. It may be here that we might seek the source, motive, energy, communality, partnerships which might enable the mental health organisations to approach complex and uncertain change.

6.6. We might consider further the kind of qualities, and the support systems needed for activity in complex areas of change. We are in some sense bringing an approach to **sources of identity** and **role** into the arena we often refer to as "skill-mix", "multi-tasking", "generic-specialist balance", "competencies" and other supporting aspects thought to be linked to some idea of organisational effectiveness.

6.7. If we can agree that the enterprise of the mental health organisation is the search for identity, meaning, social role, and human relatedness/community, we can locate its primary task as the pursuit of these qualities. We might agree to call these, cumulatively, 'well-being'.

6.8. If we can agree that the pursuit of well-being is of common and universal concern, we not only locate the experiences of people with mental disorder within the human 'family' but also place them alongside the similar aspirations of the staff in mental health organisations. The "therapeutic community" movement was one manifestation of such an approach in practice, although I am not advocating that model as such here.

6.9. If these assumptions are accepted it opens up one of the sources we have been looking for. However there are some caveats. Reference to such potential solidarity between helper and helped is not to encourage identification, abolition of the expected roles, and is also to challenge "experiential fundamentalism" on the side of the sufferer which denies the possibility of help without experience of the disorder. We would not

wish to deny either that in helping relationships authority, power, containment?? and dependency can have a legitimate place. The qualities and responsibilities which characterise the role of helper and helped I do not wish to attach or destroy. Not least because the transformational processes which takes place within the relatedness of these distinct roles is where much happens viz. - transference, counter transference etc. such that it is the difference between the roles which promotes the transformational material and experience.

6.10. I am referring here therefore to a personal, collective and organisational change as based on repertoire and range of qualities across the conceptual matrix. Diagram 3. We could characterise helping relationships in the 3 domains of change as having potentially a somewhat different emphasis such as **paternalist**; **partnership**, and **empowered**.

Development Levels ▼	Types of Change ▼		
	Remedial/Incremental	**Rapid Transition**	**Long-Term Uncertainty**
Person Role/Relationships Situations Structures	**Paternalist**	**Partnership**	**Empowered**
Managerial Challenges ➡	Problem solving Managing Continuity Improving Performance	Competition Re-direction Disjunction Vision	Responsibility Values/Beliefs Leadership Innovation
Personal Development ➡	Use of Knowledge Existing Criteria	Unlearning Re-framing New Criteria	Collective learning and creativity Imaginative responsiveness

6.11. I have referred to the tendency to reification and commodification in helping relationships in the public sector during the 80s. There have also been some unfortunate 'managerialist' tendencies in the health service which have focused on "running the business" rather than on ensuring that resources are at all possible times configured and deployed for clinical and personal outcomes for users. In short there has been a focus on the well-being of the organisation (especially new Trusts) rather than on the **organisational** consequences of organising around the therapeutic enterprise. This has been accompanied by reluctance to entertain the idea that Trusts, for example, may only be medium-term transitional structures. However we will return to the management perspective later because it may be one of the key sources in helping us understand complex, emergent change.

6.12. If there have been undesirable aspects of management which would mitigate against organisational change of a user focused type there have also been clinical practices. Yet these two functions are critical to any successful mental health organisation. They provide some of the opportunities for **unlearning** which are part of the matrix as well as being sources of understanding about the nature of transformational processes.

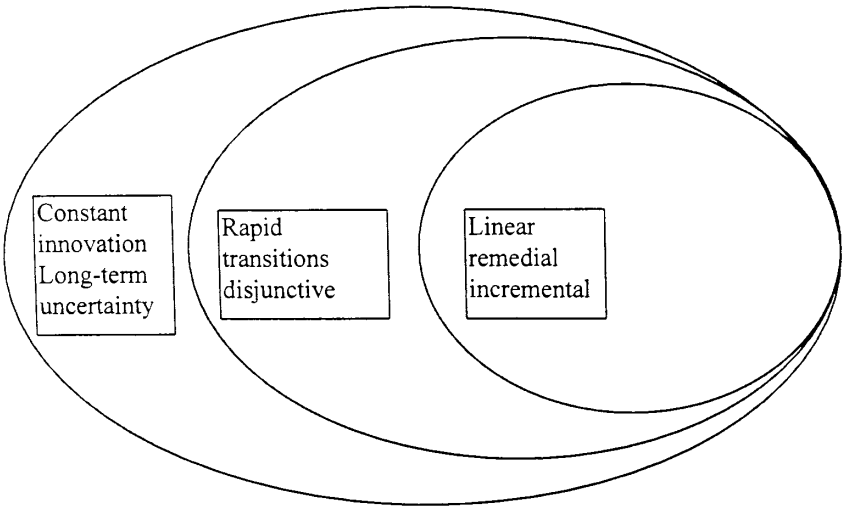
The clinical unlearning may be around the distinctions between identity; theory about mental illness; competency; role; status; reward; influence; that I suggest are conflated and too closely encapsulated in rigid roles. These are clear obstacles for many mental health

6.13. I have suggested that in approaching, acting, and sustaining change in the type of change characterised by complexity; emergence; adaptivity; and high levels of uncertainty we have to seek new and existing sources of understanding. The model proposed suggests that imagination, vision and creativity will be at a premium in such circumstances. I have also suggested that looking at the qualities and characteristics of the core of mental health organisation - therapeutic/helping relationships may also be a key source of understanding.

Finally the last element which might sustain us in the explorations is belief, and value. The framework of Seedhouse (5) can assist us here, and also the developmental process proposed by Kholberg (6). The latter includes a view of moral development which points to sources for sustaining a radical critique of our praxis.

6.14. In this short paper there is only sufficient space to begin to point to some areas for further explanation of what we understand by organisational change. The model put forward (Klein/Eason/Blackler/Richards) Diagram 3 can be seen in the light of the notes in this section as having a "venn" like quality in that the types of change seen as exclusive, linear, or developmental but as a simultaneous repertoire deployed by discerning managers, clinicians and other leaders and active participants.

Types of competing change "nested" in each other



Attitudes to helping relationships ⟶	Empowered	Partnership	Paternalist
Learning Modes in Personal Development ⟶	Collective learning and creativity Imaginative responsiveness	Unlearning Re-framing New Criteria	Use of knowledge Existing Criteria

7. CONCLUSION AND PROPOSAL

The London Commission Mental Health Report and the forthcoming Green Paper and General Election provide us with a significant opportunity to make the next step in the process of improvement in our mental health services. The historical cycles of change from the post-war developments in phenothiazine medication; reduction of institutional care; the mental health legislation of 1959, 1983; the introduction of community care models; the therapeutic community movement; the patient/users rights and advocacy movements; through to the current Green Paper show trends which will move further towards the original intentions of those ideas. There will be a mixed economy of different 'residential' and treatment facilities; there will be greater self-management by users in their care and treatment; professionals and agencies will continue to struggle to be more flexible and responsive; new money will continue to be required but existing resources will be radically reconfigured to free up existing resources before new investment can be justified.

I propose that we explore with N & S Thames the possibility of pilot development sites drawing upon the diagnosis of our report and this paper.

We have an opportunity to work with the "field of forces" that constitute mental health provision in a radical and imaginative way, in partnership, and as a committed player in respect of the quality of life which those citizens with mental disorder have a right to expect. I believe we will be judged harshly if we do not take this opportunity. I hope this paper can contribute to our thinking about the way in which we might move forward.

Huw Richards
Fellow - King's Fund

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6. 6 Stages of Moral Development. Kholberg

Chapter 1

London's Mental Health: Executive Summary

David Goldberg

The findings outlined in this book describe a service in inner London that cannot be sustained because it is unable to meet the demands imposed upon it. Services in outer London are comparable with those in other English cities. The mental illness services are in a state of transition, and we describe admirable features in many parts of the capital. However, no single service appears to have a full range of desirable features. The crisis in inner London is not due to meanness among London's purchasers or to stick-in-the-mud attitudes among its providers. The formulae for allocating resources to deprived inner-city areas need to be revisited. London is shown to have greater needs even than the socially deprived areas of other cities, and the report explores some of the reasons why this is so.

What are London's main problems?

Mental health services in London are struggling to cope with extremely high levels of demand. As wards have been closed to raise finance for community mental health services, there is now a crisis in London's in-patient services, manifested by:

- Bed occupancy rates: these have been increasing steadily, at times reaching levels as high as 125%. Figures for London are worse than those for other inner cities in England (pp. 178–180; 182–183; 192). Rates for psychosis in inner London are double those for other inner cities in England (pp. 26–28).

- The numbers of assaults and cases of sexual harassment on in-patient wards are unacceptably high (pp. 178–180). Levels of violence among London in-patients are high in national terms and are above those seen among in-patients in other urban areas. A greater proportion of London patients are compulsorily detained than in other inner cities (pp. 175; 186).

- Equity of service provision in London compared with other parts of the country areas is in doubt, in that there are people with serious disorders who may benefit from admission but do not reach the very high threshold for admission in London, although they would be admitted in other areas of the country (pp. 177; 185–187; 189).

- In-patient facilities are being used inefficiently because inappropriately placed 'new long-term' patients remain there (pp. 178–180; 182–183; 186; 191–192). There is a more than threefold variation in the provision of these facilities across London (pp. 198–201).

- Only 8% of London hospitals surveyed had liaison services meeting minimum resource requirements laid down by the Royal College of Psychiatrists, and 14% had no liaison services whatever (pp. 82–91).

- Unacceptable delays are experienced by patients, their families and staff in provision of basic services. Median delay for admission to a secure unit is 24 hours; for allocation to a CPN or social worker 7 days; for a place in residential accommodation with 24-hour staffing 7 weeks; and for accommodation with a lower level of support 8 weeks (pp. 238–243).

- The concentration of resources on attempting to meet the needs of the most acutely ill has been associated with limited and patchy provision of other important elements in long-term care, such as day care, family interventions and employment schemes (pp. 243–248).

Services in the community are not sufficient to deal with the demand:

- A major contributing factor in this is a lack of residential places with 24-hour skilled staffing to which these patients can be discharged (pp. 39; 180; 192). There is a fivefold variation in the provision of these facilities across London (pp. 198–201).

- There is a tenfold variation in the provision of less intensively staffed residential care facilities across London (pp. 198–201).

- High intensity 24-hour community services, which may substitute for hospital admission when patients are in crisis, are almost entirely absent, and home treatment of moderate intensity, with daily visits on working days, is available in only few areas of London (p. 235).

- The voluntary sector is a major provider of day and residential care (pp. 281–284; 295–297). This is not a problem: but it is a new development, and must be taken into account in service planning.

- Local Authority Services are not taking the lead in providing general adult services in any of the three areas of London we studied intensively, although they play a larger part in services for the elderly. Indeed, the NHS has taken over some traditional social services functions, and it is a major provider of both acute and long-term day care. In one of the areas intensively studied, the NHS was providing work rehabilitation services (pp. 287–288; 288–292; 304).

Other aspects of London's mental health services:

- Services for ethnic minorities: Some specific services have developed for various of London's many and diverse ethnic minority communities, but the coverage they achieve in meeting a full range of needs within these communities is thus far very limited, and there is widespread concern that the generic services are not successful in meeting these needs (pp. 143–166; 230–234).

- Time trends: Over the country as a whole, as admissions become shorter readmissions become more frequent: the number of FCEs/100,000 at risk is increasing in all areas, but has reached an all-time high in inner London, with 911 FCEs/100,000 at risk for males aged 16–64 (p. 174).

- Staff recruitment. There are currently shortages of psychiatrists, clinical psychologists and community psychiatric nurses to run the mental illness services in London (pp. 40–41).

- Mentally disordered offenders (MDOs). Rates for social deprivation correlate highly ($r = +0.75$) with admission rates to medium and maximum security beds. Use of Special Hospital beds for Greater London is almost double that for the rest of the UK – with more than twice these high rates for Camden and LSL. Even when London is compared with other inner deprived cities, these differences remain (pp. 101–105; 183–184).

- Child and adolescent services. High rates of need are indicated by high rates of children in Local Authority Care and on 'at risk' registers (pp. 70–71).

- Managers do not feel able to manage the process of change, and are constantly striving to work with budgets which are not adequate to address the needs of the populations served. Most come from a practitioner background and have had no training in management, and there is considerable job instability (pp. 331–360).

Is London worse than other large cities?

Compared with other large English cities, London has:

- a proportionately greater number of patients needing services in inner London, especially marked in males aged 15–45 (pp. 172–174);

- more discharges going to NHS or LA residential services (pp. 175–176);

- more single, divorced or widowed patients (pp. 176–177);

- a higher proportion of patients with schizophrenia among those admitted to wards (pp. 177–178);

- 11 of the 26 recent national studies of homicides by mental patients have been in London (pp. 41–42);

- more children in care (102/10K inner London; 60/10K other cities; p. 70);

- more children on 'at risk' registers (58/10K inner London; 38/10K other cities; p. 71).

If **inner deprived areas of London** are compared with **inner deprived areas of other cities**, London has:

- 33% more FCEs (pp. 184);

- higher bed occupancy (pp. 182–183);

- four times as many patients in medium secure places (pp. 183–184);

- London's purchasers spend a 35% greater proportion of their total health budgets on mental health (pp. 185).

Are there reasons for London having high rates of illness?

Characteristics of inner London:

- London is at the extreme of the national spectrum for unemployment (pp. 24–25: inner London 16.5%, UK 9.2%).
- London has the six districts in England with the highest levels of social deprivation (pp. 16–19).
- Rates of mental illness near major rail termini are higher than those at some distance from them (pp. 26–28).
- The age structure of the inner London population is different from the rest of the country, with a greater proportion of the population in the age group 15–45 (36% compared with 29%), these being risk years for major mental disorders (pp. 19–20).
- More people in inner London live in single-person households (pp. 25–26: 54% compared with 27%).

Sociodemographic characteristics of Londoners (ideally, these require special forms of mental health services):

- London has the highest rates for ethnic minorities (London has 77% of the Black Africans and 58% of the Black Caribbeans, in the UK) – some of whom have very high rates of psychoses (pp. 20–22).
- More homeless people (pp. 118–130: 50% of the rough sleepers in the UK).
- The majority of refugees live in London (pp. 22–23; 148–149).
- Rates for substance abuse are higher in London than elsewhere: 75% of cocaine seizures in the UK are in London, and 35% of people starting treatment for drug problems are in London (pp. 75–81). The rise in rates for drug problems has not been matched by increases in service availability.
- London has almost 70% of the cases of AIDS notified nationally (p. 93).

Primary care services are significantly worse in London than in other deprived areas of inner cities:

- London services lag far behind those in other cities on such measures as percentage of practices reaching targets for cervical cytology, child immunizations and school age boosters. Far more London practices do not reach minimum standards, fewer have practice nurses, and more London GPs are single-handed. These disadvantages to London persist despite the LIZ initiative (pp. 131–142).

- Where mental health is concerned, recent figures confirm earlier figures, by showing that GPs in Manchester are better able to identify psychiatric cases than those in London (p. 135).

Are these problems due to London's purchasers?

London's purchasers:

- spend a greater proportion of their budgets on mental health (18.6% inner deprived London; 13.7% inner deprived other cities; 12.8% non-deprived London – p. 185);

- are more likely to have made comprehensive assessments of local mental health needs than purchasers in other cities (pp. 181–182). Since the system is in a state of crisis despite expenditure of large sums of money by purchasers, it is clear that the formulae used to allocate resources for mental health services for deprived urban areas are in need of urgent review by central government (pp. 362–363).

How completely has London introduced community mental health services?

London's services are indeed in transition, but measures that do not require initial expenditure have taken precedence over measures that are expensive.

Good features of London's mental health services include the following:

- Multi-disciplinary teams have been introduced in most areas (p. 225).

- Sectorisation has been introduced throughout the city. It is of interest that about 17% of Trusts have already moved to sectorisation by GP rather than by social services (pp. 222–224).

- User participation in service planning is reported widely (p. 230).

- There are many examples of innovative services (pp. 260–271), although no single Trust has all the components of a desirable service (p. 255). Detailed studies in three areas of London showed great heterogeneity of service models, with little guidance available about how best to organize services. A mixed economy of care has developed on all sites intensively studied, with the voluntary sector a major provider of daycare and residential care in each area. A range of private facilities are providing care, and the voluntary sector has become important (pp. 272–304).

Poorly provided facilities include:

- Providing proper premises for mental health teams in the community (pp. 225–226: over 60% of Trusts either have none or only have them in part of their area).

- Providing services in the community on a 24-hour basis. Thus, most community services are confined to office hours, and A&E departments are central to emergency provision out of hours: A&E departments are the most frequently used facility for emergency assessment, inside or outside office hours (pp. 228–229; 235–236).

- Intensive home-based treatment is not routinely available in most areas (p. 235: 48% never available; 44% sometimes or some of catchment area).

- Acute day hospitals are frequently unable to respond quickly enough to pre-empt admissions (p. 244).

- There is a severe shortage of CPNs available to carry out the Care Programme Approach: a 'good supply' [= available for >90% of those needing the service] of nurses is reported only by 42% of the best parts of higher UPA score Trusts, to 21% of the worst served parts of lower UPA score Trusts (p. 237).

- Sheltered work is only available in good supply to about 22% of Trusts, and schemes providing support in open market employment are universally poor (pp. 245–247).

- Few areas can actually provide the recommended 'spectrum of care': mental health professionals attached to primary care were not available or in severely short supply in 58%; Court Diversion schemes in 43%; and schemes for the homeless in 60%; support for carers in 56% (p. 248).

These shortages result in unacceptable delays in providing care:

- Significant delays were reported in the time taken to allocate a CPN or a social worker to someone needing the service (pp. 237–239).

- Delays for someone needing residential care were even worse, with delays of over 2 months being widely reported (pp. 242–243).

- Where beds were concerned, delays of between 2 and 3 days are reported by some Trusts to obtain an intensive care unit bed (p. 241).

Are resources distributed according to need?

- The London Boroughs vary greatly in their levels of service provision, service availability, degree of community-orientation and adequacy of functioning, with substantial variations even within catchment areas. Sociodemographic variables explain these variations to a degree, although considerable unexplained differences still persist between areas characterised by similar degrees of social deprivation (pp. 193–249).

- The Mental Illness Needs Index (MINI) was used to compare actual provision with likely need, using statistical indicators derived from census data to take account of variations in social deprivation. The original assumptions on which the MINI was based are shown not to be appropriate for inner London: it assumes that needs are normally distributed (and they are not), and gives estimates for requirements for services which do not fit with any of the evidence outlined in this book (pp. 206–207). A revised version of MINI produces a model which better fits with the service as we found it (pp. 207–208). The figures show what would have to be provided in each London borough to produce a service with 85% bed occupancy, using no ECRs, and with no patients unnecessarily detained in hospital because there

were no facilities in the community. Extra hospital beds and extra community facilities are needed in most areas of London (pp. 217–218).

What are the cost implications of our work?

- Costs in London are higher than those elsewhere, and reasons for this have been examined (pp. 306–308).
- A set of 'actual costs' was computed by multiplying the number of services provided by unit costs, and these were compared with the 'predicted costs', using values derived from the various versions of the MINI (pp. 315–325).
- There are large variations in expenditure per 100K population at risk (pp. 316–318). Greatest expenditure on residential accommodation is on acute wards, with hostel wards and 24-hour staffed accommodation also being expensive items (p. 320).
- Where London Health Authorities are concerned, costs of residential accommodation range from £2.5–3M per 100K at risk for areas like Bromley, Hillingdon and Croydon, to £6.5–7.0M for KCW, LSL and E. London & City (pp. 321–322).
- Ten outer London boroughs, and four inner London boroughs, would appear to be functioning at about the predicted level of expenditure, or somewhat in excess of it (p. 323).
- Nine authorities are substantially underspent to the tune of between 3 and 4 million. (p. 324).
- These cost differentials have been analysed by type of facility (p. 325), indicating substantial underspends on acute beds and 24-hour staffed accommodation in both inner and outer London: only hostel wards in outer boroughs appear to have more spent on them than predicted by our models. Health authority cost differentials have also been explored, indicating that 'actual costs' are less than predicted needs by over 8 million in 5 health authorities (p. 324).

Possible Ways Forward

The evidence assembled from a variety of sources in this report demonstrates clearly that mental health services in London are working in a way that is not sustainable. The perspectives of service users and of carers need to be fully represented in future assessments of needs for services in London. Similar levels of home support should be available in all parts of the capital – currently the very wide variations between areas mean that services are far from equitable.

Resources for recurrent expenditure (NHS)

- The present national formula for allocating resources to purchasing authorities still fails to meet the needs of deprived inner cities. The York formula for taking the mental health needs of inner cities into account has only been partly introduced, as the Department of Health treats 24% of health expenditure as 'unweighted', and this

was not the intention of the economists who produced the formula originally. If the York formula was introduced as it was intended, it would go a long way towards remedying the inequalities that we have drawn attention to. An urgent review of the allocation formula is required (p. 363).

- Many London purchasers are seriously overspent, and are likely to balance their budgets by reducing their mental health spend still further in 1997/1998. This will exacerbate a situation that is already dangerous. Central planners need to reconsider the problems posed by an increased demand for mental illness services in our inner cities.

New facilities (capital expenditure)

- Acute beds are one component of a system of care and should not be considered in isolation from other elements whose availability is likely to have substantial effects on acute bed occupancy. In some parts of London, some further acute beds may be needed in the short term to alleviate pressures on staff and patients (p. 364).

- More high support residential placements (including facilities with 24-hour waking nursing staff) need to be available, for placement of the most disabled patients who currently remain for long periods on acute wards (p. 364).

- Where teams are based at sites distant from the sectors they serve, more local community premises need to be provided (p. 365).

Extension of desirable practices

- For those who do not require 24-hour care, the supported tenancies being developed in some areas of London promise to be a very useful model (p. 364). Permanent tenancies with varying levels of support according to current need allow flexibility, and may be more acceptable to younger people who have not experienced long-term institutionalization and have higher expectations regarding privacy and autonomy than the generation discharged from the asylum.

- Agreed minimum standards should be established and implemented for acceptable maximum waits for appropriate residential care. We suggest that an acceptable level of service is that all patients should normally be placed in appropriate accommodation within one month (pp. 364–365).

- Minimum standards should be set for community teams' speed of response and the intensity of support they can provide, and ways should be found of implementing these throughout the city. We propose that a reasonable minimum is that it should be possible for acutely ill or relapsing patients to be visited at least once every working day when required, for initial contact to be available within 24 hours, and for longer-term allocation to a CPN and/or social worker caseload to take place within two weeks. These standards could not possibly be met with existing levels of resource in many parts of London (p. 365).

- Family interventions for people with psychotic illnesses and their relatives should be readily available in all areas of London. Services should actively seek to give

families the opportunity to be directly involved in the care of their mentally ill relatives and fully informed about their care (pp. 367–368).

- Specific services supporting carers of people with severe mental illness should be available throughout the city (pp. 367–368).

- Procedures for maximizing the safety of staff dealing with those severely ill patients who may become violent should be developed as soon as possible (pp. 371–372).

Inter-agency collaboration

- Co-ordinated procedures should be established within each local area for monitoring services across health service, local authority and voluntary sector (pp. 361–362).

- A single multi-agency group should collate and disseminate all relevant local information within an area, avoiding any wasteful parallel procedures and ensuring maximum interpretability and availability of data (pp. 361–362).

- Reporting systems should be set up to allow the collation of data relevant to service provision and service comparison across London (this would be best organized by commissioning authorities; pp. 361–362).

- A multi-agency review of levels and types of long-term day care and of employment schemes should be carried out, with particular attention to the needs and preferences of younger people and of members of ethnic minorities (pp. 365–366).

The need for better information systems

- A regularly updated system of collection and collation of data across London as a whole should be instituted, allowing more accurate future assessment of how far services across the capital meet needs (pp. 361–362).

- Collation of information should take place at a Health Authority or Borough level, but should take into account the wide variations in service availability found between areas within the same catchment area. The services available to the population of each part of the catchment area must be considered (pp. 361–362).

- Standardized formats should be developed for recording service provision by all agencies, with clearly defined service and client group categories (p. 287).

- Future assessments of local services should not only examine numbers of places in use, but also service availability, including delays experienced and needs for service provision which cannot be met (p. 287).

- There should be an expansion of shared care registers between primary care and community mental health services (pp. 141–142).

- Detailed recommendations about special groups are to be found on pp. 46–166; 368–371.

The need for new knowledge

- A major review should be carried out of the causes of difficulty in recruiting and retaining staff, and of ways of improving working conditions and attracting adequate numbers of appropriately qualified staff to work in the capital (pp. 371–372).

- Research needs to be commissioned into the causes of the apparently rising demand for in-patient services for young men. Reasons for this are not well understood, but may include unemployment, increasing substance abuse among people with psychosis, or the alienation from community services of young men from ethnic minority backgrounds (p. 363).

- Research needs to be commissioned evaluating the effectiveness in preventing admission or reducing the length of in-patient stays of intensive 24-hour community services. It remains uncertain how far care of this type can be substituted for in-patient provision, as those currently admitted to London wards are usually very severely disturbed (p. 364).

- Improved bed management strategies and a centralised emergency bed service may have some role in prevention of large numbers of ECRs – this needs evaluation (p. 364).

- Research should be commissioned into the effectiveness of initiatives developed in partnership with ethnic minority communities, which may include training in cultural sensitivity for all mental health professionals, changes in the environments provided in mental health facilities and public information campaigns targeting ethnic minority communities (pp. 162–166; 366).

- Research should be commissioned into the nature and effectiveness of advocacy services currently provided, and whether users find them helpful. Where there is evidence that advocacy services are found helpful by users and carers, their funding should be placed on a more secure long-term footing (p. 368).

DEPARTMENT OF HEALTH

Press release

97/030

Tuesday 4th February 1997

OPTIONS FOR CHANGES TO MENTAL HEALTH SERVICES OUTLINED IN GREEN PAPER

Options for developing more effective mental health services are set out in a Green Paper launched today by Health Secretary Stephen Dorrell.

'Developing Partnerships in Mental Health' looks at ways to encourage better co-ordination between mental health and social services. It considers how the NHS, local government and the independent sector could work more closely together.

Speaking at a London press conference for the launch of the Green Paper, Stephen Dorrell said: "People with severe mental illness are among the most vulnerable in our society. They need easy access to a range of flexible, responsive and well-coordinated health and social care services. Successful joint working is often crucial to the support of mentally ill people.

"Some health authorities and local authorities are already working successfully together. But there continue to be too many cases where co-operation between health and social services is not sufficiently close to deliver high quality mental health care."

The Green Paper examines proposals which would encourage current arrangements to work more effectively. It raises the prospect of requiring health and local authorities to publish a joint mental health plan and asks whether funding mechanisms could be modified to support more effective partnerships.

'Developing Partnerships in Mental Health' also looks at possible structural change and sets out four options* for consultation:

- option one: mental health and social care authority
- option two: single authority responsibility
- option three: a joint health and social care body
- option four: agreed delegation

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* see Notes for Editors

[MORE]

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Mr Dorrell said:

"We are committed to giving a high priority to the needs of people with severe mental illness. We want to hear the views of everyone involved with the development of mental health services. Mental health and social care services need options which can be adopted without an upheaval, bringing changes that have won the commitment of agencies that need to implement them."

The Green Paper sets out the importance of service coordination but says that there are still many problems in practice - as shown through research, performance management and the enquiries into homicides and suicides by people with mental health problems.

It is clear, says the Green Paper, that people with severe mental illness do not always receive a safe, effective and seamless service. This results in a reduced quality of care, occasionally with tragic results. Poor service coordination also causes anxiety and concern for relatives, staff and the public. It says that the challenge in delivering seamless services is perhaps greater for people with mental health problems than for any other group.

'Developing Partnerships in Mental Health' features examples of successful partnerships, including joint mental health strategies for health and social services; joint commissioning using identified funding; well-developed links between primary care and specialist services; integrated mental health teams with combined arrangements for the Care Programme Approach and care management; and effective leadership by local managers.

Consultation on the Green Paper lasts until 9 May.

Notes to Editors

1. *Developing Partnerships in Mental Health*, published by the Stationery Office, price £6-85; summary paper free from the Department of Health, PO Box 410, Wetherby, Yorkshire, LS23 7LN. Copies for the *press only* are available from Department of Health Press Office: telephone 0171 210 5221.

2. The four options for structural change - all would require primary legislation - would focus at first on services for adults of working age with severe mental illness. But, in principle, could be extended to encompass a wider group of mental health services users.

Option one: mental health and social care authorities

A new kind of statutory authority, accountable directly to the Secretary of State for Health would be established, responsible for planning, commissioning and purchasing health and social services for working age adults with severe mental illness. It would be neither a health nor a local authority but it would need to work in association with both, and other existing agencies.

Option two: single authority responsibility

Either health authorities or local authorities would be designated as the single agency responsible for planning, commissioning and purchasing mental health and social care. Health authorities are the most likely choice as they spend more on mental health care than local authorities and their designation would be compatible with the continuation of GP fundholding within present arrangements. Current accountability arrangements would remain.

Option three: a joint health and social care body

Health and local authorities would establish a joint body to plan, commission and organise the contractual framework for delivering mental health and social care services. It would either commission services directly, through delegated powers and funds from the authorities, or it could co-ordinate existing successful commissioning arrangements. The joint body would be accountable to the local authority for the funds allocated for social care, and to the health authority and GP fundholders for funds allocated for health care. It would act as a single point of contact for other agencies. Staff would manage a single shared budget for mental health and social care services.

This would be optional - for authorities to choose to implement if it were appropriate for their particular local circumstances.

Option four: agreed delegation

Health and local authorities would be able to delegate particular functions or responsibilities to each other. For example, a health authority may decide to delegate the purchasing of mental health services to a local authority, accompanied by the necessary funds. Or, more probably, a local authority may ask the health authority to undertake commissioning for specific social services. Current accountability arrangements would remain. Staff would manage a single shared budget for mental health and social care services.

This would be optional - for authorities to choose to implement if it were appropriate for their particular local circumstances.

3. Malone Review: In August 1995 Health Minister Gerald Malone wrote to the chairmen of health authorities asking them to review their plans for the provision of mental health services. At same time two critical reports were published: a Social Services Inspectorate report into the implementation of the Care Programme Approach; and a report by the Clinical Standards Advisory Group into clinical care for people with schizophrenia.

4. £95 million and Spectrum of Care: In February 1996 Health Secretary Stephen Dorrell announced an extra £95 million for mental health services, published the results of the Malone review, a new guide for the health service called *'Spectrum of Care'*, and a report on 24 hour nursing homes.

5. Managers' Powers: In September 1996 Health Secretary Stephen Dorrell announced the Government's intention to abolish the power of managers' panels to discharge patients detained in hospital under the Mental Health Act. Guidance issued on how their powers should be exercised until a legislative opportunity allows the law to be changed.

6. Spending on Mental Health Services: Gross spending in 1994-95, latest year figures are available for, was £2,377 million by hospital and community health services, and £339 million by local authorities.

[ENDS]

News Release

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OPTIONS WITHOUT ADEQUATE DIAGNOSIS SAYS KING'S FUND CHIEF EXECUTIVE

"We welcome the opportunity to comment on the government's Green Paper on mental health," said Robert Maxwell, chief executive of the King's Fund.

"While it is a strange time to produce a consultation paper, since implementation will fall on the next government, the problem of lack of action between health and local authorities is real. Indeed, it also applies very strongly to the care of older people."

The Fund welcomes the focus on better partnerships between health and social services in mental health and believes that some of the options outlined in the Green Paper could increase opportunities for improvement of services.

But we urge the Government to take account of the financial cost and the disruption of even more structural changes.

More effective collaboration between commissioners of mental health services and better joint working between providers are only one element in a strategy to improve mental health services.

more/...

Secretary and Chief Executive
Robert Maxwell

We believe there is an urgent need for the Government to provide leadership for a medium term programme of local service development, informed by the views of users and carers. These should concentrate on getting a balanced and well coordinated pattern of local services in place and start to address some of the wider social problems such as homelessness.

A significant investment of resources, in London at least, as pointed out in the King's Fund's **London's Mental Health,** is urgently required to do this.

ends

Note to Editors

- For interviews with Robert Maxwell, please contact Alison Forbes on 0171 307 2581.
- **London's Mental Health** is available from the George Godber Bookshop at the King's Fund. Price: £15.