MANAGING PSYCHIATRIC SERVICES IN TRANSITION

King's Fund Working Papers
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MANAGING PSYCHIATRIC SERVICES IN TRANSITION
WORKING PAPERS

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A guide to using the working papers and checklist for action

DAVID TOWELL and SU KINGSLEY

USING THE WORKING PAPERS

Introduction

Moves towards a more community-based pattern of psychiatric services in Britain have a lengthy history. For a variety of reasons a marked increase in the pace of change has occurred in the second half of the 1980s as plans are made for the complete relocation of current services into local settings with contraction and ultimate closure of traditional hospitals. There are already more than fifty large hospitals where such plans are well advanced and most others can expect major contraction in the next decade.

Experience with these initiatives suggests that considerable difficulties need to be overcome if change is to be successfully managed. The national policy framework and resource situation is less than conducive to a radical and lengthy programme of change. Ideas about the future services required to meet different client needs are in a state of flux. There may be conflicting professional views about ways forward. Organisational arrangements to coordinate change across the health and local authorities in large hospital catchment areas are often complex. Staff interests may mobilise to protect the status quo, particularly where continuity of employment is threatened by relocation. Financial constraints may undermine the capacity to provide good local services, especially where the existing services are themselves underfunded. Indeed, as the international experience of similar changes already shows, unless the development of community-based services is managed with considerable skill, the whole enterprise may prove disappointing.

Tackling these difficulties presents a major challenge to the policy-makers, managers, professional leaders, clients and community representatives necessarily involved in any systematic approach to change. Local strategies are required which simultaneously foster rapid growth in community-based services, maintain and improve standards in the contracting institutions, and integrate new and institutional services over the years of transition.

With financial support from the DHSS and NHS Training Authority between 1983 and 1987, the King's Fund College has mounted a sustained programme of development activities designed to assist the networks of people engaged in addressing this challenge. Central to these activities have been two main streams of work:

- a continuing series of short workshops which bring together people from different locations – to date over 260 people from 85 districts and local authorities – to explore, in the light of growing experience, how best to manage transition;
- more than a dozen field development projects with particular authorities where there has been an opportunity to work with local networks of people over an extended period in helping them address issues in planning and implementing change.

In addition the College programme has sought to disseminate lessons arising from this work more widely by linking with people elsewhere engaged in confronting similar problems, by providing an information service to local managers and by writing up this work for publication.

The seven papers in this collection bring together for the first time the main written products from these activities. They are working papers in the sense that they seek to distil our thinking about different clusters of questions as these arose in our work with field authorities. In reproducing them here we have polished the texts but not tried to produce a single book, with its implications of integration and completeness. Rather we have maintained some overlap between the papers, both to reflect the inter-relation between different clusters of questions and our expectation that the papers will be used by different groups of people at different times. They are working papers too in suggesting that there is still much to be learnt about how best to manage psychiatric services in transition in the face of changing opportunities and constraints in the wider environment – not least the new challenges which can be expected from Government responses to the proposals on community care from Sir Roy Griffiths.

We see these working papers as a resource for local action. We expect people involved in managing transition to test the lessons from our work against their own local experience in devising the most appropriate ways of achieving informed change. We hope that these papers will provide a useful vehicle for reflecting on local progress and give further impetus to the wide variety of initiatives already underway around the country.

Key issues in the working papers

In our work with field authorities and in sharing experience at the College workshops we have gradually evolved a simple framework for ordering the complex range of issues involved in successfully managing transition. The most important issues are presented in the diagram below which identifies three inter-related components of concerted strategies for changes:

(i) establishing the strategic framework
(ii) developing local services
(iii) managing contracting institutions

This framework also underpins the organisation of the working papers.

- In the second half of this paper, the *Checklist for action* elaborates succinctly on this framework by providing a *diagnostic* list of questions which can be used both to review the whole local strategy for change and to flag issues which require further attention. As such it may be a useful starting point

Mapping key issues in a concerted strategy for change

for general managers, management teams, joint planning groups, and local review meetings in taking stock and planning further action. Following on from these questions, all the other papers are designed to cast light on some of the 'answers' which have emerged from experience to date.

- The second paper, *Managing psychiatric services in transition: an overview* was previously published by the Health and Social Services Journal in October 1984 as a Centre 8. It was our first effort to bring together contributions from managers and professionals already well advanced in large-scale programmes of change (including those involved with three of the first large institutions to close). Their *overview* of how this was being achieved through the development of alternative local services still seems to be relevant for other local strategies.
- The third paper, *Elements in a strategic framework for developing local psychiatric services*, provides a more precise analysis of what is involved in establishing the *strategic framework* for large-scale change. Prepared in 1986 for a study comparing the British and Italian experience of reform in psychiatric services, it is particularly addressed to managers in districts, local authorities and regional health authorities who are responsible for establishing the conditions within which local managers and professionals can work effectively towards change.
- The fourth paper, *Designing local processes for service development* describes in detail our view of the new approaches to *planning and implementation* which are required in each district and local authority if the opportunities for change are to be used to achieve a genuinely community-based pattern of local mental health services – particularly for people with severe psychiatric disabilities – and not just old services in new places. This paper, written in 1987, is particularly addressed to officers leading the process of service development. Although lengthy, it will we hope be helpful to other participants in local planning, including relevant professionals and representatives of client and community organisations.
- The fifth paper, *Assessment, rehabilitation and resettlement* shifts attention to the complementary issues of managing the contraction of large institutions. It focuses particularly on the question of how the broad decisions involved in retrenchment and the complex arrangements linking mental hospitals with wide catchment areas can be made consistent with the aspiration to plan alternative services and manage resettlement on an individual basis. The paper describes a *model of resettlement* developed with one large hospital, written in 1986. While there is much more to be said about these issues, the paper does provide a useful way of thinking about hospital planning and should be of particular interest to managers and resettlement teams.
- The sixth paper, *Collaboration for change: partnership between service users, planners and managers of mental health services*, addresses another key theme, often neglected: that of how the *users* can become more *active participants* in shaping the provision of services. Produced as a King's Fund Centre discussion document early in 1988, we have included it because it goes some way to clarifying the meaning of participation in this context and identifying practical ways of facilitating collaboration between users and other key parties.
- The seventh paper, the *Annotated bibliography*, provides a guide to *further reading* on all these issues – identifying some of the published work we have found most useful.

This work is continuing and a further paper *Values for change* will be published by the King's Fund in Spring 1989. This will focus particularly on training issues and take up the importance of investing in the development of the staff whose contribution will be vital to success in managing transition. It will aim to clarify the assumptions and approaches which underpin the design of effective local training strategies and provide examples of current initiatives which reflect this analysis.

The current programme of the Building Community Strategies Group is focusing particularly on efforts to take forward the 'spirit of Griffiths' at local level, building on the ideas already published in two King's Fund Institute briefing papers: *Promoting innovation in community care: from small-scale developments to mainstream provision* (September 1987) and *Griffiths and community care: meeting the challenge* (May 1988).

A stimulus to local action

As these comments suggest, there is a range of key people – in the strategic authorities, in the mental hospitals, in districts and local authorities, in voluntary organisations, user groups and community agencies – who are, or should be, involved in developing and implementing concerted strategies for change. Ideally we envisage members of this extended network coming together to review local progress, perhaps using the checklist which follows, and identifying issues requiring further attention. In turn this may lead to the identification of individuals or sub-groups interested in examining the ideas in relevant papers and making proposals for strengthening local action. On some themes we hope part or all of a particular paper will be useful material for local seminars and workshops (for example, on designing the planning process or developing partnerships with service users). We also envisage that the collection as a whole is something managers will want to come back to from time to time as these local strategies unfold.

The important point in all this, however, is for local people to use ideas and experience from elsewhere in a creative and critical way. Progress towards better services is only likely on the basis of informed local leadership and the willingness of people to come together to make their own futures.

CHECKLIST FOR ACTION

Achieving change in established patterns of service provision requires vision in relation to the possibilities available for the future service together with concerted action on a number of different fronts in order to turn the vision into reality. To move beyond an institutional mental illness service, local facilities need to be growing at the same time as the hospital is reducing its bed numbers. Resources need to be transferred into community services, but not at the cost of quality and morale in the hospital which will continue to be part of the whole service. Further complications are introduced by the traditional pattern of provision, where hospitals have typically served two or three districts. Providing community services creates an opportunity to offer psychiatric service users access to a wider range of helping agencies, but this will depend on securing the involvement and collaboration of the agencies at an early stage in the development process. Existing staff need assurances about their future as well as training for new skills: and it is important to consider how new services will be staffed.

All these issues arise at a local level, but effective action will be contingent on the development of an appropriate policy framework by district and regional health authorities, worked out in conjunction with relevant local authority bodies.

The following list of key points to be addressed when changing the focus of psychiatric service provision is not exhaustive but is intended to suggest a framework and provide a starting point for managers and planners in health and local authorities faced with the challenge of leading psychiatric services into their next phase of development. We anticipate that the questions outlined could also be a useful tool for voluntary organisations and community health councils when determining the extent to which local statutory services are addressing the challenge of change. Used in a local context, we expect that each question will generate other questions and issues which need to be resolved and acted on.

We have grouped the questions into sections which have common or complementary themes. Each group of questions is preceded by a brief introduction explaining why these issues are important and indicating how the questions might be used. This is intended to be an aid to planning and developing new services. It may suggest areas which have not yet received sufficient attention locally, or inspire local planning groups to develop new approaches to problems which they have been grappling with unsuccessfully for some time. It also provides a short checklist which should indicate the health (or otherwise) of the local development process.

1 Establishing the conditions for large-scale change

Achieving radical changes in service provision, of the sort implied in the transition from institutional to community-based services, requires commitment and support at all levels of the service system. Success is most likely if the legislative framework, ideological aspirations, financial policies and management structures are mutually reinforcing. National and regional policy is an essential prerequisite in supporting local change. National government needs to establish the policy, legislative, organisational and resource framework necessary to promote the change. Given that this is not necessarily forthcoming, the challenge at local level is to do the best possible within the constraints; and to make the most of those opportunities for change and development that do exist. In particular the large hospitals serving several districts provide a management challenge which needs to be addressed in the arrangements for developing local services; and investment will be required to ensure that there is a cadre of skilled and committed staff to lead and carry through change at local level.

1.1 Have the relevant health and local authorities identified clearly who has responsibility for creating a region-wide strategy for change and monitoring progress in its implementation?

1.2 Has political support been generated around a vision of the future service which will encourage commitment of the resources necessary for implementation?

1.3 Are there clear management arrangements for coordinating changes in service provision across the catchment areas of each large hospital during the years of transition?

1.4 Is there adequate investment in the skilled staff necessary for tackling the planning and implementation issues arising in major change and for supporting other staff involved?

Financial and manpower policies to promote change

To effect change successfully, districts, local authorities and regions will need to have developed a range of policies addressing the financial and personnel issues which will be raised. These policies will need to be informed by and capable of supporting and enhancing the vision of the future which service development is aiming to achieve.

1.5 Have financial policies been established which promote the development of local services while protecting standards in the contracting large hospitals?

1.6 Are there manpower plans and professional training arrangements to meet the staffing requirements of a new pattern of service?

1.7 Have personnel policies been negotiated which encourage staff commitment to change and prepare people for their future roles?

1.8 Is responsibility for managing deployment of staff clearly defined?

2 Moving out from the large hospitals

Current development opportunities in many districts centre on providing alternative local support services to people who are living in large hospitals. The process of contracting these large institutions will need to be handled carefully and sensitively, with due regard for the interests of the patients and staff involved. The keystones of successful change are: ensuring that the quality of alternatives offered to people to live outside the hospital is adequate and suits their needs; maintaining the quality of the remaining services in the institution as it contracts; and communicating fully and effectively with staff. Committed and energetic leadership is required to ensure that these aspects of change are fully addressed.

2.1 Have management arrangements been established which provide consistent institutional leadership while linking relevant parts of the large hospital to the developing local services in each district (or locality)?

2.2 Are there well designed arrangements for managing relocation and rehabilitation for residents of large hospitals?

2.3 Are there opportunities for individuals to be involved in decisions about their own futures?

2.4 Are plans for the movement of patients into local services based on their individual requirements?

2.5 Is there a development plan for the large hospital designed to achieve improvements in the quality of care and maintain staff motivation during the period of contraction?

3 Developing local services

Whatever the strengths of broader policies and strategies, the main impetus towards the design and implementation of community psychiatric services needs to be generated locally and reflect particular local circumstances. Moreover the process of service development itself needs to be carefully designed if the wide range of relevant interests and sources of expertise are to be used effectively in creating new services which are responsive to individual and community needs and sensitive, therefore, to differences which arise from class, gender and ethnicity.

3.1 Have the health and local authorities in each district established a leadership group with clear responsibility for developing the total district psychiatric service?

3.2 Is the contribution of large hospitals serving the district adequately represented in the leadership group?

3.3 Has this group created forums in which voluntary organisations, staff from the existing service and trades union representatives, service users and their relatives, and community groups, can all contribute to the service development process?

3.4 Had a variety of service development teams been created to explore priority issues and give impetus to local innovation?

3.5 Are these teams working to the leadership group in its role of providing key directions for the service as a whole?

3.6 Are planning teams for specific projects operating sufficiently 'near the ground' to take account of individual needs?

Encouraging participation in service development

These planning arrangements provide the scaffolding to support a variety of contributions to service development. The psychiatric services have an impact on the lives of many people in the community, often over the long term. In addition staff have a wealth of experience to offer to service design and have a major interest in the way in which future services develop. This suggests the value of bringing all of these varying perspectives into the planning of new services at an early stage, and ensuring that adequate time is given to air and explore different positions, together with a search for ways to resolve differences.

3.7 Are patients and current service users regarded as active participants in change and offered access to independent advice and representation?

3.8 Is investment in communication and participation sufficient to ensure that staff fully understand proposals for change and contribute themselves to shaping new services?

3.9 Are sensitive efforts being made to promote public support for local services and to involve the community in desegregation of people with psychiatric disabilities?

3.10 Are opportunities created for working through the conflicts in professional expectations and other views likely to arise in introducing significant change?

Establishing a vision of the future service

Turning to the 'content' of new services, a critical aspect of planning is the need to use these processes of discussion and debate to work towards a vision of the future pattern of provision and its key elements. There is of course much to be learnt from experience elsewhere, but at the same time there needs to be a creative endeavour in which local people clarify their values and aspirations and begin to test new designs in practice.

3.11 Does planning challenge existing assumptions by investing in the exploration of innovative forms of provision for the future?

3.12 Has detailed attention been given to making explicit the principles upon which future services should be based?

3.13 Has a broad vision of this pattern of services been agreed which makes clear how the future experiences of clients with particular needs should differ from the present?

3.14 Are local initiatives informed by comparison with how similar client needs are met elsewhere?

3.15 Are services being designed which meet individual client requirements?

Information for planning

While planning for individuals must necessarily start from information about – and from – individuals, planning for a district also requires aggregate data about patterns of present use and likely future needs for psychiatric services from the population. In identifying the nature and scale of elements in a balanced service system, information is also required on the resources – particularly of finance and manpower – which may be available or could be generated.

3.16 Are plans informed by systematic data on likely future needs for services, arising from the requirements of both current clients and potential local demands?

3.17 Are these service planning activities realistically linked to financial and manpower planning?

4 Ongoing management and quality safeguards

Implicit in this approach to achieving change is the need for close integration and interaction between the planning, implementation and ongoing management of local services. Planning cannot be considered as a 'once and for all' task but is rather a continuing process of development which learns from experience as implementation proceeds. The key test of success of course is the extent to which the opportunities and support offered to users improve the quality of their lives. Service design should include the management arrangements and operational policies which specify how the intended goals are to be reached. Success however cannot be assumed: part of the ongoing management responsibility must be concerned with regularly assessing the impact of services on the lives of users and include detailed evaluation studies where most appropriate.

4.1 Are there clear arrangements for implementing and managing the planned pattern of community-based services?

4.2 Are there operational policies for each part of the local service which specify objectives, working methods and coordination arrangements with other elements of the service?

4.3 Are arrangements for quality assurance built into the routine functioning of local services?

4.4 In particular are service outcomes being monitored against the agreed principles and objectives?

4.5 Are there arrangements for evaluating innovations and learning from experience as implementation proceeds?

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WORKING PAPERS

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Managing psychiatric services in transition: an overview

Edited by DAVID TOWELL
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*Increasingly, the development of local psychiatric services depends on the relocation of resources currently invested in large institutions. Managing this transition successfully presents major challenges, particularly where closure is envisaged. Strategies are required which simultaneously provide a coherent framework for large-scale change, encourage the development of good local services and sustain the quality of institutional care during the years of transition. Drawing on contributions from Don Braisby, Peter Colclough, Ann Davis, Mariella Dexter, Donald Dick, Audrey Emerton, Barry Foley, David King, Andy Mack and David Milner, this paper (published in 1984) reviews British experience and identifies what has been learnt to date about achieving new patterns of psychiatric provision.**

I Introduction

The last 30 years have been a period of significant change in British psychiatry, the common theme of which has been a shift away from the inheritance of institutional provision towards a more community-based pattern of services. The 1975 'Better Services' White Paper[1] provides the fullest official expression of this trend, while current national policies have been helpfully restated in a DHSS paper[2] used in the regional reviews. The recent 'Care in the Community'[3] initiative provides new financial mechanisms to encourage relocation of hospital residents, while an HAS document[4] draws particular attention to the importance of developing local services for mental illness in old age.

These policies have not, however, evolved in a single, coherent way. Nor have they been implemented uniformly. There has been particular uncertainty about the future contribution of the large mental hospitals. In 1961, the then Minister of Health, Enoch Powell, was able to foresee rapid decline in much of the nineteenth century inheritance. Nearly 20 years later the Royal Commission argued in contrast that most mental illness hospitals will continue to be needed into the next century. In fact, in 1984 the 100 or so traditional mental hospitals still provide services to some 60,000 in-patients.

It is clear, however, that the cumulative impact of post-war policies is such that further significant change can be anticipated, albeit in economic and social conditions considerably less favourable to the development of community-based mental health services than hitherto. There are about 30 large hospitals where radical strategies are being actively considered, in some of which firm plans for the complete relocation of current services have already been approved, and many others can expect major contraction in the next decade.

The impetus for these changes arises from several sources. The development of alternative services and the efforts of hospital staff have already greatly reduced the size of traditional hospitals and this in-patient decline will continue, not least through the death of long-stay residents. After a century or more of use, the capital costs of sustaining buildings and replacing plant looks increasingly forbidding. With no growth in the total revenue available to authorities, development must be funded from transfer of existing resources recognising, as the DHSS puts it, that 'reductions in (in-patient) numbers do not bring matching cost savings unless a hospital is closed'.[2]

Complementing these economic pressures, many districts are committed to becoming 'self-sufficient' in psychiatric provision through creating local alternatives to the mental hospitals. There is no doubt, too, that government concern with the development of priority services, expressed through the regional review mechanism, is pushing the relocation of psychiatric services up the strategic planning agenda.

With encouragement from DHSS and financial support from the NHS Training Authority, the King's Fund is developing a programme of action research, educational and consultancy activities designed to assist the networks of people currently engaged in addressing this challenge. Over the last 18 months we have made contact with many of the localities where plans for the relocation of hospital services are already well advanced.

This paper is one product of this work. Within a framework suggested by our explorations, we have invited field staff with particularly relevant experience to contribute their views on different elements in the strategies required. We begin with a commentary on the broad approach being adopted in one locality where plans for radical change are well advanced. Subsequent contributions are organised into three sections concerned respectively with establishing the strategic framework for change, developing good local services and managing the contracting institutions. We conclude with suggestions about how these different aspects of planning and implementation can be brought together effectively.

So far in Britain there is no local project which demonstrates the complete relocation of hospital provision. All our contributors are in the position of still 'travelling hopefully' rather than having arrived. The lessons identified should therefore be regarded as tentative, to be refined in the light of subsequent experience. Through the medium of the King's Fund, this paper is also an invitation to readers to contribute to the wider sharing of experience through which knowledge about how to manage transition successfully can be advanced.

II The Exeter experience – a case study

In a few places, considerable progress has already been made in developing concerted strategies for achieving major change in psychiatric provision. Particularly impressive are efforts being made by

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*1988 – The three main hospitals described in these case studies, Exminster, Darenth Park and Banstead are now all closed and subsequent experience has been studied in more detail. The Darenth Park study by N Korman and H Glennerster, *Closing a hospital*, was published by Bedford Square Press in 1985. Reports on Exminster and Banstead are currently being written by King's Fund staff and will be available early in 1989: Exminster by Virginia Beardshaw from the King's Fund Institute, and Banstead by Sholom Glouberman from the King's Fund College.

Exeter health authority and its neighbouring districts to move away from the inherited pattern of centralised institutional services. David King, Exeter's district administrator, describes the way management has given momentum to these efforts. This local case study shows the importance of developing a broad vision of future services backed by the commitment of members and officers, building a collaborative approach between health, local authority and community-based organisations, and establishing management arrangements which promote change.

For a century and more, Exeter has been a centre for mental illness and mental handicap hospitals serving Devon and Cornwall. Royal Western Counties (mental handicap) and Exminster (mental illness) hospitals provided a lifetime alternative for their inmates in place of whatever existence they may have had in their own communities. All sorts of people were admitted who today would never come near a hospital. The hospitals conditioned them to a communal life with little or no expectation of returning home. This custodial system was in full flower when the NHS took over the hospitals; there were 4,000 residents in 1950 and the same number 10 years later, though in 1960 things had begun to change. The 1959 Mental Health Act enabled newly recruited consultant psychiatrists and social workers to help many of the inmates move to the community and prevent any more potential new recruits from permanently swelling the hospital population. In 1970 there were 3,000 residents and in 1980 2,000. During the period 1960 to 1980 many things had changed, which increasingly questioned the appropriateness of centralised hospitals. Mental illness and mental handicap were no longer seen as debilities best dealt with by permanent removal from society, but as conditions susceptible to a range of treatments and therapies, or assisted by increased social support.

Care staff, with encouragement from consultant psychiatrists, had anticipated and encouraged the gradual trend to community care, relying on the steady infusion of additional development funds to build a small increment of new services as the years went by. By the late 1970s a number of consequences of this process became apparent. Though patient populations were declining, the hospitals were not getting smaller but demanding more resources and more management attention. Development funds were drying up, but the hospitals were still attracting the lion's share of the small amount available. The radical conclusion was that instead of waiting for history to solve the problem, we would close the hospitals and use the resources to create local services.

The idea, quite simply, is to return services and revenue to the four other districts in Devon and Cornwall and to create a greater spread and provision of local services in the Exeter district, to be paid for by the closure of the two main hospitals, which between them employ 1,100 staff and cost £10m per annum. It is a conversion programme in which all the existing resources and more will be employed to better effect in the new service than the old. More than 50 per cent of the cost of NHS residential care is spent on revenue and capital costs to feed and house in-patients. Outside hospital these costs are borne by other agencies (housing and social security) thus releasing NHS funds to be spent on direct care. It is a simple fact overlooked by many that, even in this hard economic climate, you can actually increase the money available for mental health and mental handicap services.

Planning a local service

The Authority has demonstrated its commitment and purpose in the conditions it has set for the total programme. These have been developed as it has come to appreciate the magnitude and importance of its self-imposed task. The chairman has stated the first and most important condition simply as follows: 'People must have the services they want, not what the authority says they can have'. This means participation in decisions and choice, not Hobson's Choice. Community services must relate to actual communities and the Exeter authority, in conjunction with the community health council, county, district, parish and town councils has set about understanding the bounds of natural communities within the district and discussing, consulting and negotiating what the needs are and how they can be jointly met. This is 'locality planning'.[5] In addition, local consumer groups are being involved particularly in the development of mental handicap services. A major action research programme has been commissioned into the needs of all handicapped people in the district aged 16 to 25 based on *their*opinions and those who support them. Joint planning with social services, education and housing has become an imperative, not an optional extra.

Formerly the NHS concentrated virtually its whole attention on improving hospital services; planning for community provision with local authorities was a marginal activity. Now that NHS and social services are operating in the same arena, joint planning, joint operation and the co-ordination of services is essential – as a process it has come alive. An indication of this is that staff are now employed in two of the districts, jointly accountable to health and social services authorities for developing joint plans.

The authority is aware that what it initially provides may be less than appropriate – too conditioned by past traditions – and that services must be under constant review to ensure that they are sympathetic to the needs of people. Services must adapt and not be set in concrete.

The other main condition laid down by the authority is that there should be every incentive to manage the change from existing centralised services to local provision. This can only be achieved if all concerned see a positive and better future for their clients and themselves.

In a locality clients have a resident staff at their service (people they know) and staff have a known group of clients to serve, not just a ward or department to run. For everyone the human context is more real and rewarding. The philosophy of the service being created is that people remain in touch with each other and can help each other to grow and develop. At the core of this programme of change is an understanding with staff that there will be no compulsory redundancies but every opportunity offered for them to play a part in the new services. In consequence there is full commitment and support by staff associations and trade unions for the overall programme.

The NHS is fortunate that these organisations have national policies in sympathy with a move to community care, providing staff are protected and can share in planning and implementation. Ministers have responded positively to what they see as a bold initiative by delaying Exeter's support services tendering timetable, recognising that only one major change can be undertaken at a time. Receiving districts have cooperated fully and the region has underwritten the whole programme. County and district authorities are committed to an integrated joint plan.

Managing and financing change

Management arrangements have been designed with built-in incentives to effect change, for each management unit is responsible for the whole transition. They run existing services, design the new and implement the transition. Thus there is every encouragement to move to what is seen as a brighter future. For example, one unit will move an entire psychiatric service from Exeter to Torbay (the neighbouring district); it is responsible to both authorities for managing the hospital in Exeter that it is closing to develop new services in Torbay to a timetable for completion in 1988. The health authorities have set budgets, overall timetables and sanctioned the style of service required; the units have the task of delivering the goods.

The Exeter health authority has devised a method within its own £75m budget to finance capital and revenue bridging finance. There are arrangements for the transmission of revenue between districts on the closure and transfer of beds, wards and ultimately hospitals. The RHA has underwritten these arrangements and it is greatly to its credit that having accepted the plan its involvement is based on the annual reviews and meetings when required. Within Devon and Cornwall, meetings of health authority and county committee chairmen with chief officers ensure that theory and paper plans are translated into practice.

Maintaining momentum

The changes occurring in Exeter are the outcome of many years argument, discussion and planning. It became apparent in the late 1970s that it was not possible both to improve hospital care and develop community services and it was agreed to devote all our resources – money, but more importantly, time, effort and imagination – to the latter. Hospital closure plans are a small though important part of this process, alerting everyone with the will for change and releasing resources to achieve it. Hospitals do not close themselves and there are detailed programmes and timetables for their run down. Infinitely more important is the determination not simply to cast people out and leave them to fend for themselves, but to ensure that the new community services are of the best standards that can be achieved. 'Savings' arising from hospital closure are protected for investment in the new service and more resources are being added to them. Although there are developed plans for community services, they are not like blueprints for a building, unchangeable after the contract is met, but dynamic so that they can be changed and adapted in the light of experience.

III Establishing the strategic framework for change

As the Exeter case study suggests, the complex problems involved in relocating services requires that a clear strategic framework be established. The most important aspects of this framework include arrangements for shaping and co-ordinating service development across the catchment areas of each large hospital, financial policies which promote local initiatives while protecting hospital standards, and agreed personnel practices which encourage staff commitment and prepare people for their future roles. In South East Thames RHA a major project to replace a large mental handicap hospital with local services has been underway already for six years. Reflecting on the experience of this project Audrey Emerton, the region's nursing officer, and David Milner, a senior finance officer, identify some of the lessons for region's role in the task of relocating psychiatric services.

The experience of planning the relocation of services from Darenth Park – a mental handicap hospital with 1,000 beds serving seven health districts and eight London boroughs – has convinced us of the need both for an explicit sense of direction and clarity on the roles of the different interests involved if major transition is to be successfully achieved. With Proverbs 3 in our minds, '*Where there is no vision the people shall perish*', regional officers identified at the outset the need to establish broad policies and principles to guide the process of change. Equally it has been important to identify who is responsible for what in translating this vision into local services on the ground. In a project of this complexity we have learnt that region must accept its responsibilities for leadership and coordination, as well as providing specialist support to local service development.

Having established the role parameters, it is also essential that everyone understands not only the philosophy and policy but also the part each individual has to play, whether member or officer. There is a need for total commitment to the exercise in hand and a spirit of determination, but not to the exclusion of flexibility. In a rapidly changing situation, with declining resources and conflicting priorities, commitment by all concerned is vital. The withdrawal of one or more participants – in our case, for example, the withdrawal of the local authority representatives for a period of a year – can throw the balance and interrupt the programme at whatever stage.

When considering the roles of different interests, the inclusion of representatives of voluntary bodies, parents and relatives in the planning of services has proved to be invaluable at local level and latterly the inclusion at regional level has proved very helpful. When the project began in 1978, region also invited DHSS observers, recognising that the fast changing policy scene nationally was one on which we needed to be kept updated.

Experience has shown that it is vital to engage the interest of a group of members of health and local authorities to negotiate policy issues crossing health and local authority boundaries. This was particularly important prior to clarification of government's 'Care in the Community' policy, given the scope for conflict with regard to the transfer of funds across boundaries to meet new service provision outside the 'joint funding' mechanism.

Funding transition

The RHA recognised the need to develop a sound financial framework from which the relocation of services could be planned. The RHA needed a funding policy which provided the necessary stimulus to change without involving protracted and difficult discussions. A funding policy was developed which offered every DHA a standard cost, based upon existing average levels of provision in the region for patients who are transferred out of the large hospital.[6] This allows DHAs to know exactly the level of resources they are likely to receive in the strategic period for this care group, and they can plan their own pattern of care on sound financial assumptions. The RHA has also earmarked substantial capital resources to provide replacement facilities in receiving districts.

The focus on developing local services must not, however, detract from the problems of maintaining a service in the large hospital. Throughout this project, region has been mindful of the problems of maintaining the quality of life of the residents, meeting the anxieties of relatives and retaining staff morale over a period of 10 years.

Clearly the development of appropriate personnel policies is essential and their timing is crucial if policies are to give in practice the necessary assurance to staff about their future employment. Also important is the provision of a comprehensive training programme. To this end, the RHA and Kent University jointly appointed a training coordinator in 1982.[7]

At the beginning of this project, it was hard to visualise the complete closure of the large hospital. In fact, many staff would not accept that the hospital would close. As progress has been made it has now become possible to produce a relocation control plan with target dates for particular changes which makes clear to everyone the precise detail of how the hospital is to be finally closed in 1987.

Implications for mental illness services

These are just some of the lessons we have learnt from the Darenth Park project which have relevance to the similar, if less complex, process of relocating psychiatric services. Region has for several years been encouraging more purposeful development of psychiatric services in the context of better collaboration among the various interests involved. These efforts are now being pursued more actively.

Because mental illness services are usually less complicated – large institutions typically serving three or four health districts – the extent of the region's involvement in planning may be reduced, although it needs to ensure that a framework for change is established and that support is available to promote local development. It must also monitor progress through the review process. An essential part of this framework is again a funding policy which aims to change the allocations to DHAs to reflect the usage made of large hospital facilities and make available additional resources, both revenue and capital, to achieve closure of one or more large hospitals during the decade. Because of the size of the mental illness care group budget (three times that in mental handicap) the commitment of districts throughout the region will be required for this major shift to local services.

Personnel policies

Another vital element in strategies for managing transition is the policies and practices through which the personnel implications are addressed. Drawing further on the Exeter experience, Peter Colclough, the unit administrator, and Andy Mack, secretary of the local Cohse branch, describe the approach which management and staff organisations have adopted in tackling the relocation of services from Exminster Hospital. Each states briefly their personal view before jointly describing the practical steps through which their approach has been given substance.

Andy Mack. Accepting change is never easy, but to suggest the closure of a large traditional mental illness hospital gives rise to its own very special and very real anxieties. Is my job safe? What will happen to my patients? Is this just another excuse to cut costs in the NHS? These and many other vital questions must be answered if the concept of change is to be accepted. Any district health authority contemplating such change must give priority to the welfare of its staff. Guarantees must be given on job security. Plans for the future of the service must be discussed fully with groups of staff affected and, where necessary, with individuals.

Peter Colclough. In any discussion of the move to a new service, there is much talk of the redeployment of resources – of reinvesting the resources tied up within outdated institutions – in a newer pattern of care. Some resources, such as steam boilers, rent, rates, etc, will be realised as 'free money' if an institution is closed, but the majority of any service's resources are its existing staff, and it is not sensible to think of beginning a process of decentralisation without the full involvement of staff and staff organisations.

Informing and involving staff

Management commitment to the decentralisation exercise is clear and unequivocal, but we have tried from the outset to involve people in helping us arrive at a view of the new service rather than simply impose solutions. Within Exminster there are great reserves of skill and expertise, and the people who possess these qualities must be involved in developing the way into the new service. It is important to stress continually that the exercise is aimed at creating a new service, and not simply doing away with the old. The phrase 'the run-down of the long-stay institution' should be avoided at all costs. It is unhelpful, and creates the wrong atmosphere. An emphasis on creating a new future implies the creation of new job opportunities, and a continuing role for existing staff.

In informing staff about plans for decentralisation, you will not be telling the staff organisations anything new. Their national policies recognise the trends within institutional care and the need for a new style of service, as Cohse's document, *The Future of Psychiatric Services*,[8] clearly shows. Starting from a seminar two years ago, we made a commitment to a joint approach to change which has been successfully carried forward in all our work to date. One aspect of this approach has been an internal effort to ensure staff are fully aware of developments. Open meetings for all staff are now a regular feature of life at Exminster and these, and other smaller discussions with wards and departments, are important ways of communicating information. We have found that some themes, the things that worry people most, constantly recur. To overcome these worries and counter distortions requires constant repetition of the true nature of proposals and the safeguards offered to individuals.

We have also aimed to involve existing staff in detailed planning of new services. Staff currently involved in caring for people away from their natural environment have a very clear idea of how they should be looked after closer to home. Ward-based staff have been involved in groups developing plans for locality services, and their practical contribution has been particularly valuable.

If staff are involved from the start, the new services become their services, and start to take shape. Locality based services for the elderly confused now exist in shadow form within Exminster. For example, the patients from Tiverton and Honiton who will return to units in these towns early next year have been brought together, and the team of staff who will move with them is being appointed. We hope that this approach will produce a period of transition in which existing staff participate fully and thus help to reduce the associated trauma.

Procedures for staff affected by change

The development of new services means change in the way people work, and there is joint recognition that some staff practices and the composition of the labour force will alter. The new services will certainly bring a change in the place of work, and for many staff a welcome closer contact with the community they serve. There will be fewer ancillary jobs than are required to service Exminster, and an increase in the number of nurses and other professionals employed. For this reason all appropriate vacancies in Exeter's other health services are now offered first to those affected by change. Equally, some existing staff will take the opportunity to shift into new roles. For example, two jobs in a recently opened staff hostel were reserved for ancillary staff; the people appointed are now highly valued members of the hostel's team.

The arrangements for filling vacancies in new and existing services are all contained within a jointly agreed procedure document.[9] From the start of the exercise it was clear that moves on this scale involving 750 staff at Exminster would require an explicit framework – a set of rules that would be understood and applied by all concerned. Early discussions of change were dominated by the fear of redundancy, although the authority had given a guarantee of no compulsory redundancies. The way to remove the understandable anxieties seemed to be to produce a procedure which would amplify this guarantee, with details of the safeguards and benefits available to individual staff.

This procedure seeks to provide individual members of staff with every opportunity to participate in determining their own future. The agreement aims to match staff participation in the planning of new services with a mechanism to make change in the place of employment and, in some cases, in the type of work done, as easy as possible.

The procedure has now been in operation for nine months, and we are learning from experience. To date, 80 staff have succeeded in obtaining alternative employment in other units within Exeter, and a small number have transferred to the Torbay and North Devon health authorities. The major moves of services and staff have yet to come. There will be individual difficulties, but we feel at this stage that the procedure agreement, and the work involving individual staff outlined above, will see all our existing staff in new jobs by the end of 1987.

Finally, the joint consultative committee within Exminster plays a crucial role in the decentralisation exercise. It is the forum in which the complexities surrounding many of the moves can be unravelled.

IV Developing good local services: defining the model of provision

In the context of an evolving strategic framework, it is the task of local management and professional leadership to mobilise participation in the creation of new patterns of provision and identify innovative ways of providing community-based alternatives to the institution which better meet the range of client needs.[10] *Donald Dick, psychiatrist member of the mental illness unit management team, describes the principles* *informing the development of comprehensive and decentralised psychiatric services in West Dorset.*

Building a satisfactory service for the mentally ill in a health district has to challenge some past assumptions. The first is that people with persisting mental illness need to live in hospital. The second is that there has to be a single central place for psychiatry where all professional mental health staff are based and from which they travel out, like missionaries to the field. The first assumption never was true: far more mentally ill people have always lived at home than in hospital. The second has been eroded over the last 30 years by the establishment of sector psychiatric teams, day hospitals, day centres, sheltered work, accommodation schemes, group homes, mental illness hostels and the networks of community treatment that have been so strengthened by the development of community psychiatric nursing. General practitioners play a larger part than formerly in the management of the mentally ill, not only because of advances in therapy but through partnership with specialist psychiatric services working locally.

Elements of a dispersed service

West Dorset is not a complex health district and for that reason can act as a laboratory to test ideas that might have wider application, certainly in other rural and provincial districts and, with some changes of scale, to city services as well. For the past 12 years or so we have been moving towards a new pattern of service. Herrison hospital has been the county asylum since 1863 and still serves both Dorset districts. So there are two main tasks, one is to separate out the revenue that provides for East Dorset patients and hand it over to that district to build its own self-contained service; the other is to use the West Dorset revenue to build a new community-based service of our own.

The original intention of building a new pattern of service for West Dorset has held over the years. The vision was one of a dispersed service, retaining central units for intensive treatment and characterised by a local presence in each discrete community within easy reach of the patients' homes. The image was one of slicing the hospital like a cake and moving the slices out to five market town sites. We wanted the service to be characterised by its comprehensiveness, that is meeting the needs of the whole range of people with mental illness wherever they lived. It needed to be readily accessible to everyone who used it – no more than a short journey from home. We wanted to deliver care mainly in the living room or the high street and not in a distant hospital. For people with chronic mental illness we wanted a domestic rather than a hospital environment. For elderly people with dementia we wanted to support them in their own homes for as long as possible, giving a range of day care, support and relief to their families. Where continuing care is needed we believe it should be in local community hospitals. Therefore we began to develop the network of buildings and staff on which to base the different levels and ranges of the psychiatric service.

Making gradual progress

To date, the achievements have been to establish community psychiatric teams in four sectors. A community mental health centre with day hospitals for both general psychiatry and the elderly serves Weymouth, the largest centre of population. This also includes 11 refuge beds. The market towns are served by intermittent day hospitals (the 'travelling day hospital'); there are five small day hospitals for the elderly mentally ill; community psychiatric nurses are separated for general psychiatry and for the elderly in the teams. We have just opened the first 20-bedded ward for the elderly mentally ill in the Blandford community hospital. For the chronically mentally ill formerly in hospital, there is a jointly managed resettlement scheme providing places for about 350 people. Twelve years ago we estimated that there were about 300 patients in Herrison hospital who might live outside. Most now do so. The added numbers are those who have been judged in need of sheltered accommodation, group homes or supervised living meanwhile and have not needed to enter hospital permanently. The scheme also offers a network of social clubs, occupation and leisure activities. The local authority has added in a mental illness hostel, a multipurpose activities centre for all kinds of disabled people and a day centre for the elderly in the main centre of population. A 12-bedded hospital hostel for new long stay will be opened next year.

Our central place for psychiatry in the district is a modern admission clinic in the grounds of the psychiatric hospital only just outside the county town. We have yet to suffer the supposed advantages of a new unit cramped into the site of an overcrowded district general hospital. The other district (East Dorset) is making vigorous attempts to establish its own local admission beds.

Although progress towards a new service has been slow, it has been consistent and we believe we have achieved as much as most. Certain features have been helpful. First, a consistent strategy over many years, adopted as policy in turn by the old hospital management committee, the area health authority and now the district health authority. Next, identified component parts that can be built and staffed step by step by the steady closure of the mental hospital. Thirdly, the policy has been devised and is therefore 'owned' by senior medical, nursing and administrative staff who actually run the service. Fourthly, the district-wide service has been managed as a unit long before the recent reorganisation with very substantial control of our own budget, now complete. Finally, the district health authority is committed to checking the objectives of the strategy against achievement at definite intervals. These helpful features may also suggest a prescription for action elsewhere.

Designing the development process

As Donald Dick's concluding observations imply, the effective development of comprehensive district services requires that the process of planning and *implementing new services is itself carefully designed. David Towell and Tom McAusland describe an approach to service development which seeks to avoid common planning pitfalls.*

As we argued earlier, development of local services to replace the present contribution of large hospitals represents a major challenge to health and local authorities. Unless this challenge is addressed with considerable commitment and skill, there is a real danger that opportunities created by a major shift in resources will be wasted. Nevertheless, our discussions with people in different areas suggest that there are often considerable weaknesses in local planning. To overcome these weaknesses, we outline here an approach to service development which seeks to involve actively a wide range of people with different interests; mobilise political weight behind a broad vision of how future services should differ from the present; use this vision to make gradual steps forward in a necessarily uncertain environment; and monitor progress so as to improve performance in the light of experience.[11]

Over the last decade the NHS has, of course, gained considerable experience in service planning. However, the characteristics of psychiatric provision raise particular difficulties for the usual planning arrangements. Psychiatric services seek to meet a wide variety of needs through a complex pattern of provision. Both the subject matter and output of these services are relatively problematic. Fragmentation of existing services – relying on different agencies, professions and contributions from inside and outside the district – can mean that local joint planning lacks coherent professional leadership and has a weak voice in the forums where resource allocation decisions are made.[12]

Leadership and participation

In confronting these problems, a starting point is the identification by authorities of a leadership group with clear responsibility for developing the total district psychiatric service. As the 'Nodder' report[13] recommended, the core of this group is likely to be the psychiatric services management team, working under the auspices of the joint care planning team and with representation from health district, local authority and relevant parts of the large hospital.

Such leadership needs to recognise that a wide variety of other interests are affected by change and should be involved in shaping new services. Included here are less senior staff working locally and in the large hospital, and representatives of voluntary organisations, community groups and clients. Sensitive responses to inter-related problems and changing circumstances are more likely where people share in the search for progress. Successful implementation is also more likely where those affected have contributed to the plans.

This participative approach implies careful design of planning activities and the availability of skilled administrative support to facilitate effective work in different forums. An important role of leadership is to generate the trust necessary to work through the conflicts likely to arise in any serious debate about major changes. The core planning group will need to sponsor sub-groups to undertake well-defined tasks and create a range of relevant project teams operating sufficiently close to the ground for some of those involved to know personally existing clients for whom services are being designed.

Conferences can be useful in encouraging innovative thinking about the services required. Staff development activities can also be closely tied to the issues arising in providing new services.[14]

Wide involvement, particularly of community representatives, can be further promoted where an important dimension of service planning focuses on the needs of people in small localities. Again, the Exeter district experience of 'locality planning' illustrates what is possible[15] and this emphasis is equally relevant in urban areas where local populations differ considerably in ethnic, class and age structure.

Sharing the vision

The most important aspect of this approach to service development is the way these participative arrangements are used to link local people together in sharing information about current services and shaping common images of a more desirable future.[16] In much traditional planning there seems a tendency to define future services by extrapolation from the present – reproducing old services in new places. This weakness is particularly likely where pressure to commit capital allocations leads to investment in expensive buildings with limited flexibility.[17] More generally, plans which lack robustness can readily become outmoded as aspirations, needs and resource assumptions change.

In more innovative planning, the information required includes the views of clients, relatives and front-line staff, as well as statistical data from epidemiological studies and routine returns available to senior managers.

Particular emphasis needs to be put on detailed information about the experiences and wishes of individual clients. Discussion is required among people with different perspectives to develop a critique of present provision and identify alternative ways of meeting community needs. Also valuable are opportunities to learn from services elsewhere. In all these activities, thinking about *which* clients require *what* services should precede discussion of *how* these services are to be provided and by whom. The main aim is to negotiate a broad vision of the future pattern of services which makes explicit the principles upon which services are based and states clearly how the experience of individual clients with particular needs should differ from the present.

Finally, continuous monitoring is an essential element of this approach. The future is necessarily uncertain and the knowledge upon which services are planned is incomplete. It is useful, therefore, to regard service development as a learning process. Review of progress in the light of explicit objectives offers the means to reinforce successes and ensure services respond quickly to emerging weaknesses. Where implementation is faster in some localities than others, an action research orientation toward these 'vanguard areas' can generate design guidance for services elsewhere.[18]

V Managing the contracting institutions: leadership for institutional change

The third main part of any concerted strategy for change relates to the management of the contracting large hospitals and the ways people there, both staff and patients, are involved in the transition to new services. Victoria health authority is responsible for two distant hospitals and plans to close one quickly to create resources for improving the other and developing local services. Mariella Dexter and Barry Foley, respectively administrator and director of nursing services in the unit team managing these hospitals, describe their role in institutional leadership and their approach to sustaining the quality of services in the hospital identified for closure.[19]

The Banstead/Horton strategy for psychiatric services was conceived at the end of the 1970s as an innovative, yet pragmatic, plan to facilitate the early transition of services for the mentally ill from remote institutions to local communities in London. The basis of the strategy was that by concentrating resources – financial, human and physical – in one hospital (Horton), the other hospital (Banstead) could be closed on a relatively short timescale to release additional resources for improvement of standards and community developments. Moreover, merging the two hospitals during a period when admissions were reducing, or would be diverted to local DGH units, would enable us to create a single viable (even dynamic) hospital in an evolutionary mode, rather than to oversee the fading away of two archaic institutions.

With NHS restructuring, Victoria health authority inherited the management of the two hospitals and vested responsibility for the process of strategic change in a yet-to-be-appointed management team for the new mental health unit. Not surprisingly, there was some loss of momentum during this period while coherent management and new leadership emerged.

Continuity and communication

It is said that management has been talking about closing Banstead hospital for 20 years. Many staff have been there that long; most managers have not. The consequence appears to be that while staff affected by the closure may state a belief in the change, a true conviction that it will actually happen is lacking. Rather, experience (or is it folklore?) indicates that if the threatened institution nods agreement and waits long enough, most formally appointed leaders and agents of change will either go away by getting promoted or 'reorganised', or entrepreneurally will die. Recently both of us have heard tales that we are leaving or are about to move on and promises made by such transitory leaders are quickly construed as worthless. While undoubtedly there is a strong element of wishful thinking here, the largely unsolicited plethora of management changes in recent years has given considerable credence to this myth. Ironically, changes of management may not be conducive to the management of change. For this reason our principal task has been to establish stable leadership and to demonstrate a strong personal commitment to the objectives of our psychiatric strategy.

Over the past year we have sought to develop a continuous dialogue with staff affected by the changes both through formal mechanisms, such as a joint management/trade union working party on implementation, and informally by personal contact. In recent months we have established a programme of weekly half-day visits to Horton hospital when small groups of staff from Banstead hospital have the chance to talk to members of the unit management team about the future and to see the hospital where they may soon be working.

We acknowledge, however, that this is merely the starting point: constant reinforcement is required with the concomitant massive investment of management time and energy. Like others, initially we underestimated the communication difficulties and the effort required to get the message across, not least in relation to staff job security where from the outset the authority adopted a no compulsory redundancy policy.

Here the involvement and support of trade union leaders is crucial. Institutional leadership can never be the unique preserve of a formal management group but is shared with the natural leaders mandated by the rank and file. The latter invariably provide more stable leadership than the appointed 'bosses' and may even enjoy greater credibility.

Early this year, perturbed that our message did not appear to be reaching staff at operational level, we tried to accelerate communications by seeing staff individually without trade union support. Although in this way we were able to reach directly the individuals concerned, this unilateral action proved counterproductive, since a withdrawal of trade union co-operation silenced perhaps the most effective internal communications network in the hospital. Clearly, there are no hard and fast rules in the communications game and management must establish an effective channel of its own. While in certain circumstances a decision to by-pass acknowledged staff representatives by a direct approach may be warranted, we need to ask whether in the end it will be worth the price.

Improving standards

In the past mental illness services across the country have been notoriously under-funded. Victoria health authority recognises that a strategy for change is only likely to have a chance of success if it offers a realistic opportunity to improve this situation and is not seen as yet another cost cutting exercise. Accordingly, we have given a commitment to improve standards progressively at both hospitals. In the past two years £400,000 recurring revenue has been injected to improve staff: patient ratios and a £2m rolling capital programme has been established for Horton.

Last year £200,000 was spent on minor improvements to Banstead ground floor wards with the longest remaining life. An improved environment for both patients and staff has been created by refurbishing, with the emphasis on comfort and privacy. Before diverting revenue from Banstead to Horton or to community services, we aim to achieve staffing levels equivalent to at least the median of major mental illness hospitals nationally. In this way, Banstead is experiencing substantial growth in its declining years.

So that this policy does not inhibit the release of financial resources for community developments, an agreement was reached with the RHA to fund developments on an investment capital basis, ie Victoria health authority borrows the capital now to establish community services and improve hospital standards and pays back later, with the savings which will accrue once Banstead hospital has closed. This 'bridging loan' is central to our capacity to maintain standards in the old service while getting the new one off the ground. We do not see our short-term, high-cost development programme for Banstead and Horton as a wasteful investment in crumbling buildings (which may ultimately be bulldozed), but as an expression of our moral obligation to existing patients and our commitment to the staff who will provide the psychiatric services of the future, however they are organised.

Despite our efforts, however, most staff are wary of working in a closing hospital and, having uplifted nursing and domestic staff establishments last year, we are now finding posts difficult to fill. In these circumstances retaining existing staff becomes crucial and there are a number of initiatives managers can take. Involving staff in the process of change, from the ward-based assessment of patients to be relocated to the detailed planning of new services, promotes interest in the future service and helps to set the closure of a hospital in its strategic context.

In summary, our task as leaders is to keep the Banstead and Horton Strategy moving in a way which engenders maximum commitment from all those involved. This entails a complex operation on three fronts: in the closing hospital, the remaining hospital and in the nascent community services in London. It presents an enormous challenge and demands deep reserves of energy and, above all, time. Having been immersed together in this process of change for the past year we have come to learn, sometimes painfully, that *real*change inevitably takes longer than anticipated.

Involving service users

The people most affected by the relocation of institutional services are, of course, the existing users of these services, yet ways of seeking patient views and ensuring their active participation in change often seem poorly developed. Don Braisby, mental health services project leader with Camden social services department, Ann Davis, lecturer in social policy at Birmingham university, and Tom McAusland, draw on some current examples to suggest how these weaknesses can be overcome.

In the taxing and confusing process of moving towards a different pattern of services, the consequences of change for people who are living as patients in the large institutions is something that is very easily lost sight of by professionals. From the psychiatric literature it is clear that little attention has been given to the experiences of patients who have been involved in major changes in services. Yet tens of thousands of people have moved and are currently moving from large hospitals to a variety of living situations in the community. They have a wealth of views and ideas on what has helped and hindered in managing this change. If the shift to community-based psychiatric care is to benefit those living in psychiatric hospitals then some urgent consideration has to be given to patient participation.

Planning for individuals

Some pointers to what is possible can be derived from experience at Friern hospital, a large hospital currently involved in the process of dispersal. There, nursing and social work staff are engaged in several small-scale projects designed to bring service planning close to the day-to-day life of patients and staff in long-stay wards.

For one group of five men – with 130 years of institutional life between them – this has involved a number of practical steps. By allocating a staff member to spend one or two days with individual patients it has been possible to build up a real understanding of daily existence for each person – an understanding which is not available in nursing or social work records or from the common assessment instruments. Sharing these 'portraits' has enabled staff to draw out the issues which seem to be important to patients themselves in considering the full range of needs which new services should try to meet. It has also underlined the central importance for patients of being treated as valued members of society. Joint problem-solving sessions have then been used to suggest service options genuinely appropriate to these needs and realisable with the resources which can be made available.

Earlier plans for these men envisaged their transfer to Part III homes. In the light of this exercise, however, ward staff, together with a project development team who now knew the men individually, identified a different approach. A priority was to help the men regain basic living skills lost during lengthy hospitalisation. Because of difficulties that can arise in transferring skills learned in one setting to another, the activities in this programme take place as far as possible in the shops, cafes, day centre etc in the neighbourhood where it is hoped their new home will be found. A group of local volunteers of similar age has been recruited to act as individual befrienders of the men and to help them make other links in the neighbourhood. Negotiations have also begun with a housing association to provide an appropriate house where the men can live together.

This tiny example is not unique but the lessons we have learned from it are significant. Information drawn from professional records and large-scale dependency surveys provides an inadequate basis for determining the precise form of future services. Planning becomes effective only when seen as an opportunity for learning in which all those with a stake in the outcome are involved. The intensive demands on staff resources in the short-term required by this approach are more than balanced by the avoidance of 'bottlenecks', mobilisation of skills and positive commitment to 'making things work' which come from knowing personally the people being planned for.

Patients as partners

Further information about appropriate ways of involving patients in relocation arrangements can be derived from the experience of people who have successfully moved out from institutional care after many years in hospital. From interviews[20] with many such people, a number of themes have emerged of importance to staff in implementing future transition programmes.

First, most patients found the initial announcement by staff of a proposed move into the community a shock. In hospitals where the announcement was followed by changes in ward routine to allow opportunities for the exchange of feelings and worries (eg over coffee mornings) patients found support. It was not just exchanges with staff which were valued but time spent listening to how other patients saw the change. This contrasted with hospitals which followed the initial announcement by immediate changes of ward as well as routine. These additional changes meant there was little time to talk things through and only added fresh worries to their concerns about the transition.

Second, it seems staff often feel that they should shield patients for as long as possible from the delays or uncertainties which inevitably occur in the transition process. This view is not shared by patients themselves who felt less worried by being involved in the main ups and downs of negotiation for property and places than being subject to last-minute announcement of changes.

Third, patients valued the opportunity to create and maintain links with a particular area or possible living situation (eg through contact with volunteers from that area) even if the specific details of the move were still uncertain.

Fourth, where patients are being selected to join resettlement programmes, selection has to be sensitive to the friendships which have grown between people so that the process of change does not sweep away personal contacts. Successful community living situations were often ones which continued friendships established on the ward or elsewhere.

Fifth, many patients experienced a gulf between individual learning programmes in the hospital and the demands they were faced with when they left. The lesson seems to be that there is a need for a substantial re-examination of current rehabilitation programmes. They have typically been based on a professional view of the needs of disabled people which results in them being measured (or assessed), trained to compensate for their defects and moved on if they pass the test.

In fact successful resettlement work displayed very different features. Patients valued the space and the time to get to know other patients in unsupervised settings before moving out with them. They experienced rehabilitation not so much as teaching new skills but as allowing them opportunities to display skills which had become rusty since admission and they found programmes which were created for the detailed practical reality of the situations they were moving to much more useful than general preparation for the supposed norms of family or group living.

Independent advice and advocacy

It should also be acknowledged that at times in any process of transition the interests of staff and patients may not be the same. If patients are to be involved it is in their interests to have access to support in putting forward their views to the professionals. In this country one recent development which might in future play an important role in the transition to community services is the growth of citizens advice bureaux and law centre projects attached to large hospitals. Tooting Bec, Middlewood, Springfield, Prestwich and Cane Hill hospitals already have experience of the successful operation of such independent advice services for patients, relatives and staff. It seems likely that all large hospitals experiencing rapid dispersal will require a service of this kind to provide independent, but authoritative, support for one-to-one advocacy projects, patients' groups and related initiatives.

A better quality of life and survival in the community requires active engagement with a new environment. From the start, treating patients as people who are participants in change is vital if they are to face a new life with confidence.

VI Towards concerted local strategies for managing transition

The contributors to this paper have written from different roles, professional backgrounds and local situations. While any single paper cannot aspire to be comprehensive, it seems to us that together their contributions add up to quite a full picture of the action required in achieving major change. Despite different briefs, the overlap between sections shows both the connections between issues and the general relevance of a few broad propositions.

Perhaps the most significant lesson to emerge is the vital importance of ensuring that development of new services is grounded in a real appreciation of individual client needs. It follows that planners should listen carefully to what patients think and build into planning methods for representing their interests. A second general lesson is that policy-makers and professional staff need to review and make explicit the principles informing service design if current opportunities are to be well used. The multitude of decisions involved in establishing new services are only likely to prove cumulative and coherent if there is widespread commitment to a vision of how future services are to differ from the present. A third key lesson is that successful implementation requires planning to be closely linked with resource allocation processes recognising, however, that the resources to be invested in new services come not just from the NHS but from local authority services, social security and the supporting generic community agencies.

Our contributors also demonstrate that sustained progress towards local services in the face of difficult management problems requires a stategic framework to guide change and extensive local initiative. The strategic framework includes clear management arrangements to provide direction and co-ordination for service development across the large hospital catchment areas; financial policies which promote alternative services while protecting existing standards; and personnel arrangements which encourage staff commitment to implementing change. The purpose of this framework is to foster energetic leadership in each district and widespread participation in creating new local services. Success depends, therefore, on both the adequacy of this framework – mainly the responsibility of senior managers and their authorities – and on the effort, sensitivity to client views, collaborative skill and learning ability of a large number of staff.

While not everything can be done at once, the scale of the challenge requires that in each large hospital and its catchment area, an extensive network of people share in shaping concerted strategies for change. We conclude with a summary of key issues to be addressed in the form of a checklist for local action. We hope readers will find the checklist a useful starting point for reviewing their own experiences and enhancing their capacity for successfully managing the transition to good local psychiatric services.

Managing transition: a checklist for local action

Establishing the strategic framework

1 Have the relevant health and local authorities clearly identified who has responsibility for establishing a concerted strategy for change and monitoring progress in its implementation?

2 Have the authorities involved negotiated a broad vision of the future pattern of services, and made explicit the principles upon which this vision is based?

3 Are members and senior officers demonstrating political backing for this vision, particularly in making resources available for developing local services?

4 Have clear management arrangements been established for coordinating changes in service provision and reallocating resources across the catchment areas of each large hospital during the years of transition?

5 Have financial policies been established which promote the development of local services while protecting standards in the contracting large hospitals?

6 Have personnel arrangements been negotiated which encourage staff commitment to change and prepare people for their future roles? Is responsibility for managing redeployment of staff clearly defined?

7 Is there adequate investment in the skilled staff necessary for tackling the planning and implementation issues arising in major change and supporting other staff involved?

Developing good local services

8 Have the health and local authorities established in each district a leadership group with clear responsibility for developing the total district psychiatric service? Is the large hospital contribution adequately represented in this leadership group?

9 Working to this joint planning group, have a variety of service development teams been created to explore priority issues and give impetus to local innovation? Are teams for specific projects operating sufficiently 'near the ground' to be designing services which meet individual client requirements?

10 Through these and other means, does the planning process encourage participation of all the interests affected by change? Specifically does this participation extend to front-line staff, clients, community groups and voluntary organisations?

11 Does planning address the particular mental health needs arising in each of the small localities which make up the district population?

12 Are these participative arrangements generating commitment to a shared vision of future services which makes clear how the experiences of individual clients with particular needs should differ from the present?

13 Are these planning activities realistic, in the sense of being closely linked to well-grounded finance and manpower assumptions? Are they also well-informed by systematic data on likely future needs for services?

14 Does planning challenge current assumptions by investing in the exploration of innovative forms of provision for the future? Are local efforts informed by comparison with how similar client needs are met elsewhere? Are opportunities created for working through the conflicts in professional expectations and other views likely to arise in introducing significant changes?

15 Are relevant training opportunities being provided on the scale necessary to prepare staff for the exercise of new roles and skills? Is this training closely integrated with the implementation of new services?

16 Is there commitment to learning from experience as implementation proceeds? Is progress being

monitored against explicit objectives? Are arrangements for quality assurance being built into the routine functioning of local services?

Managing the contracting institution

17 Have management arrangements been established which provide consistent institutional leadership while ensuring that relevant parts of the large hospitals operate as part of the total service to each catchment district during the transition?

18 Is the investment in communication and participation adequate to ensure staff fully understand proposals for change and themselves contribute to shaping new services?

19 Does the planning process also treat patients as active participants in change and ensure they have access to independent advice and representation?

20 Is there a development plan for the large hospital itself, designed to achieve improvements in the quality of care and maintain staff motivation during the period of contraction?

Acknowledgement

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MANAGING PS [illegible]

MANAGING PSYCHIATRIC SERVICES IN TRANSITION
WORKING PAPERS

3

Elements in a strategic framework for developing local psychiatric services

DAVID TOWELL and SU KINGSLEY

Introduction

Reform in psychiatric services necessarily emerges from the complex interplay of bureaucratic, professional and community pressures, within the wider economic, social and political context.[1,2] In devising strategies appropriate to developing psychiatric services in the next decade, it is important that lessons are learnt from earlier experience.

The immediate post-war years saw Britain with a government committed to major social reconstruction. Its large majority reflected a popular mandate for radical change, including introduction of the Welfare State and creation of the National Health Service. The mental hospitals were incorporated into the NHS and though most were slow to benefit, there was a scatter of institutions, typically with young doctors back from military service in leadership positions, where an early start was made on a programme of liberalisation. Wards were unlocked, custodial attitudes challenged, meaningful work provided for patients, links established with the developing community health services and rehabilitation actively pursued. These changes were carried further in some places through the development of the therapeutic community philosophy with its stress on democratisation and open communication. The doctors became administrative therapists and Britain led the European movement towards social psychiatry.[3]

These innovations took time to spread and twenty years on were still being introduced in some places. By the mid-60s however the movement for reform had changed in significant ways. The 1959 Mental Health Act gave legal expression to some liberalisation in the status of mental patients but the psychotropic drugs were commonly given much of the credit for previous achievements. In the National Health Service there was expensive investment in district general hospitals and psychiatric units were gradually incorporated into these centres of high technology medicine. Further reform in psychiatry was seen as achievable through the integration of acute provision for mental and physical illness and it was hoped that such integration would also bring new public attitudes to psychiatric disabilities. The administrative therapists again became proper doctors and the therapeutic community approach declined in influence.[4]

Twenty years on, the situation of British psychiatry reflects this history. The emphasis on rehabilitation and the shift of acute services have led to a large reduction in the occupancy of mental hospitals – a reduction which would have been much more dramatic but for the inappropriate admission of confused elderly people turning many institutions into huge old people's homes. After a century or more of use, the physical condition of the original asylums is declining and they are increasingly costly to maintain. There are again significant pressures for change, focusing on closure of the institutions and the use of their resources to develop local alternatives.

Past failure to integrate different aspects of reform and to sustain the momentum for change means that the implementation of good community-based mental health services still constitutes a major challenge. Moreover progress must be sought under conditions which are quite different from those of earlier reforms. The Thatcher government is committed to cutting public expenditure and its social policies offer limited support for liberal attitudes or concern with the disadvantaged. Much of the current impetus for change derives from the National Health Service bureaucracy and its preoccupation with more efficient use of resources tied up in the mental hospitals. The vision of alternative provision is poorly defined, however, and there is considerable danger that the relocation of resources will merely reproduce old services in new places, rather than develop new services.

In our view the scale of this challenge has been underestimated. Change in psychiatric provision will only be attained where it is possible to achieve new status for people with psychiatric disability, new roles for staff and new public attitudes all within a single movement for reform.

We cannot be sanguine about the prospects for success in the next few years. Nevertheless, from what is already happening in different parts of Britain,[5] often on a small scale, we are convinced that there are significant opportunities to make progress – even in the existing climate and framework for public services. This paper examines the practical strategies required to make good use of these opportunities; its focus is on the pattern of mental health services required to support people with severe psychiatric disabilities.

Elements in strategies for purposeful change

Our analysis suggests that successful strategies for developing community-based psychiatric services have two fundamental requirements: change should be *principled* and change should be *systemic*.

Defining service principles

In arguing for principled change, our concern is to overcome the weaknesses in provision which can be expected if the combination of ill-defined national policies, professional conservatism and traditional pragmatism allows present assumptions to colonise the future. It is vitally important that change should be guided by principles which make clear how new services will enhance the life experiences of people with particular psychiatric disabilities. This is especially the case for people requiring help on a long-term basis; those who may be most at risk of being devalued and have certainly suffered from inadequate services in the past.

As the MIND manifesto *Common concern*[6] argues more fully, explicit service principles provide the foundation both for service design and subsequent quality assurance. These principles need to address two questions: the first is concerned with effectiveness and acceptability of services to individual users; the second is concerned with accessibility of services and their relevance to needs of the local population.

For the first, we believe principles should stress the importance of guaranteeing the rights of people with severe psychiatric disabilities, maintaining their dignity and avoiding stigmatisation. They should also underline the objective to provide services which will help them to live in ordinary neighbourhoods and minimise their handicaps. On the second question, the aims should be to provide services which are comprehensive, offering a range of support to everyone in the local population with severe disabilities and recognising variations in need among different users.[7]

Addressing the total system of psychiatric provision

In arguing for systemic change, we aim to draw attention first to the complex organisation of major public agencies and their interactions with the people and communities they serve; and second to the variety of interest groups necessarily affected by the transition to new patterns of provision. The questions for reformers are:
– How can a coalition in support of principled change be assembled?
– What activities will be required to secure implementation of local services based on these principles?

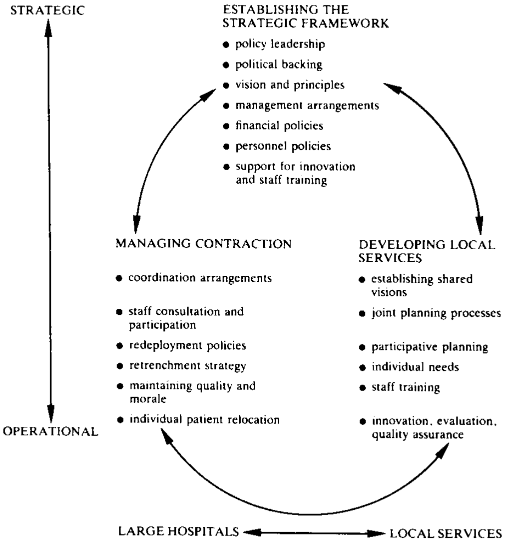

Figure 1 Key issues in a concerted strategy for change

In examining the current organisation of relevant services in Britain, we have found it useful to distinguish three main components of systemic change:

- establishing the strategic framework;
- managing existing services, particularly the contracting mental hospitals;
- developing community-based services.

Figure 1 illustrates the interdependence of these three components and lists key issues which need to be addressed in planning action. Our discussion of these issues seeks to identify lessons from British experience about how best to achieve purposeful change.

Establishing the strategic framework

As we noted earlier, in contrast with other periods of reform, the main thrust behind current plans to relocate resources from the institutions stems from government and regional authorities and their quest for efficiency.[8] As with other bureaucratic reforms, it is all too easy in this situation for mental hospital staff and patients to see themselves as victims of change rather than active participants. While impetus from government and regions may be important to sustain the momentum for change, new patterns of services cannot be achieved solely by 'top down' planning and mechanistic control. Our own work with authorities in different parts of the country has shown that change in services at the point where people with psychiatric disabilities and front-line staff meet requires strong local leadership and widespread participation in an organic process of development.[9]

In the past, psychiatric services and their users have not been given consistent priority in the contest with more 'popular' causes and acute medical specialities. Given the magnitude and duration of the transition towards local services, progress is only likely to be maintained where efforts are made to build explicit political support for reform – for example, in the interest and commitment of local and health authority members. As experience in the South East Thames region has demonstrated,[10] this political support is particularly important in ensuring that the necessary resources are made available both to fund local services and meet the extra costs involved in transition.

There is no doubt that the substantial assets of money and skill tied up in the old institutions could be used more effectively in providing community-based alternatives. Experience in Exeter, Riverside and the North East Thames region, suggests, however, that the total public sector cost of acceptable new services is likely to be greater than current expenditure because past provision has been of poor quality. The money would be drawn from a wider range of sources, including significant increases from the social security budget. During the transition period there is also a need for 'bridging' finance to create the infrastructure for new services and meet the increasingly expensive unit costs of the contracting institutions.[11]

It follows that the task of government and regional agencies is to establish a broad strategic framework designed to encourage local leadership and provide incentives for decentralised service development. Among the issues this framework will need to address are the rate of change towards community-based services, the financial policies required to offer incentives for local innovation while protecting standards in the contracting institutions, and the personnel and training policies necessary to foster staff commitment to change and ensure that appropriately skilled people are available to provide new services.

It is also important that this framework recognises that support for people with psychiatric disabilities should in future be drawn from different public agencies, including the National Health Service, local authority social services, housing, education and leisure provision, employment services and Social Security Offices, as well as from the voluntary sector. In the past these services have often been fragmented because coordinating development across the multiplicity of agencies in a large hospital catchment area is difficult. Nevertheless successful change is unlikely unless the main agencies work together in planning and implementation. Our own research has shown that the creation of joint forums and wider networks which address the total system of psychiatric service provision are essential mechanisms for coping with this complexity.[12]

Managing existing services

A central component of the current service system is, of course, the mental hospital whose position and contribution require careful attention during the period of transition. There are two possible risks here. One is that existing institutional concerns will dominate local planning and seriously handicap the fresh thinking required to create community-based alternatives. The other is that the mental hospital will be excluded from planning and its staff left to struggle with the consequences of development elsewhere. Both risks can be avoided if relevant parts of the hospital are represented in the local planning and coordination arrangements for the successful relocation and rehabilitation of inpatients.

At the same time it is vital to recognise that management of the institution during a lengthy period of contraction is itself a major task, requiring staff committed to the maintenance and, where possible, the improvement of standards while relocation is proceeding. Neither the maintenance of standards in the contracting hospital nor appropriate preparation for patients moving to local services is likely unless efforts have been made to gain the support of existing staff for change.[13] How this can be done is again well illustrated by experience in Exeter and Riverside.[14]

Developing community-based services

New patterns of local services can only be created by replacing traditional bureaucratic approaches to planning and implementation with an organic process of service development which promotes widespread participation in achieving change based on explicit values and principles. We have already argued the importance of a principled approach to change. As people in North Lincolnshire have demonstrated,[15] it is at local level that all the legitimate interests (people with psychiatric disabilities, the public, professional groups and representatives of the service-providing agencies) can be engaged in the debate. An essential task of local leadership is to ensure that this debate starts from the experiences of people with psychiatric disabilities. The new social psychiatry will then be just as concerned with promoting their status and participation in the wider community through attention to income, homes and jobs as with interventions to reduce handicaps and encourage personal development.

In the past, particularly where planning has addressed the requirements of large populations, client needs have been aggregated into ill-defined categories which fail to reflect individual diversity. There has also been a tendency to concentrate on people's disabilities rather than their abilities, and to define needs in terms of the way services are currently provided rather than by asking what assistance is actually required. The resulting services have often been agency-centred rather than client-centred. The new approach to planning begins instead from a careful assessment of individual strengths, needs and wishes and seeks to deliver services which meet changing individual requirements.[16]

It follows of course that local planning must involve people with psychiatric disabilities themselves. Where necessary, independent sources of advice and representation must be established to strengthen the consumers' voice in service development. For example, staff from Friern Hospital and Camden Social Services have shown that this may involve local project teams in intensive 'getting to know you' exercises with patients living in mental hospitals. These exercises centre on the person's own experiences in order to identify his or her future requirements.[17] The development of outreach services from generic citizens advice bureaux and more specific one-to-one advocacy schemes are two possible ways of offering patients independent support, as well as assisting their access to services like social security.[18] People with psychiatric disabilities already living in the community must also be included, whether or not they are regular users of existing specialist services.

The development of genuine community-based services cannot of course be achieved solely by welfare agencies and their professional employees. Rather the participative approach to planning must seek to foster partnership between community services and the community, both to gain public support for new patterns of local services and, in the longer term, to promote fuller integration of people with psychiatric disabilities in community life. Appreciating individual client needs, developing services which are responsive to local differences – for example in demography and ethnicity – and building this partnership are the more likely to happen where planning for the populations of large administrative areas (health districts, boroughs, and so on) starts by addressing the requirements of small localities. The wider experiments in decentralising public services are demonstrating this.[19]

In the context of these different aspects of innovative planning, new patterns of services can be designed. Essentially, service design involves assessing how well alternative models of provision meet individual needs and are consistent with agreed principles. Typically a range of alternatives should be considered, drawn from promising experience elsewhere and from local invention.[20]

Again, as the Exeter experience suggests, this creative process of local service development must go beyond planning to ensure that good intentions are realised in practice and high quality services are maintained and improved in the light of experience. First, this involves closely linked planning and implementation. Staff who are to lead service delivery should be involved in planning these services; service design should be expressed in detailed operational policies and management arrangements; and all staff should be trained in the procedures required to put these policies into practice. Second, local services should build in explicit arrangements for quality assurance, again starting from the principles upon which services have been based. Third, running through these local development processes and growing from the shared experience of new forms of service provision, there will need to be a major effort to clarify the values, concepts and personal skills required to underpin the practice of community-based psychiatry.

Energising reform

To return to our starting point: these prescriptions for incremental reform must be related to the wider context. Britain's continuing economic difficulties and the influential ideologies which devalue public services and seek to stretch further the informal caring contribution of families are a major handicap to the modest aspirations we have described. There are dangers for vulnerable people that change in this climate will at best result in 'transinstitutionalisation' and at worst add to their poverty and neglect.[21]

While recognising these dangers, our position is that people with severe psychiatric disabilities cannot wait for more desirable economic and political conditions. More positively, our analysis of the best of what is already being achieved in different parts of the country shows that progress *can* be made in enhancing the status and support for people with psychiatric disabilities in their own communities.

We appreciate the scale of the challenge. The British welfare state is the largest and most complex bureaucratic organisation in Europe. To use its strength as a vehicle for addressing individual need in a community context will require inspiration, commitment and ingenuity. We have summarised what we believe should be elements in the movement for reform. The most important is the need for local people to reclaim the leadership for change – mobilising active coalitions of relevant interests (including consumers, community representatives, progressive staff, managers and policy-makers) around a vision of future services which is rooted in the experience of people with psychiatric disabilities and reflects their entitlement to something better.

We believe such leadership can link further reform of psychiatric provision to the wider values of early post-war achievements which are still reflected in popular support for the welfare state. In particular, the concepts of *citizenship* and *community*, suitably updated to reflect the social conditions now prevailing, have continuing appeal. For people with psychiatric disabilities, citizenship implies the right to participate in economic, social and cultural life and to receive the support necessary to make this possible – decent housing, income, work opportunities and professional help when required. The idea of community suggests that these rights can only be realised through a partnership between public services and ordinary people. The fuller participation of people with disabilities would constitute a community achievement, reflecting the community's commitment to accepting all its members and developing all its human resources.

In conclusion we should emphasise again that our expectations for the benefits of psychiatric reform are modest. While community mental health should benefit from collective action designed to secure wider social change, we remain doubtful about the converse proposition: that society itself can be changed through initiatives addressed primarily to people already suffering major disadvantage.[22] However, what we *learn* while making some gains for and with this vulnerable group of people may well have rather wider relevance. We may see more clearly what would be involved in achieving citizenship and community for us all.

Acknowledgement A slightly amended version of this paper is in Ramon S and Gianichedda MG (eds). Psychiatry in transition: the British and Italian experience. London, Pluto Press, 1988.

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MANAGING PSYCHIATRIC SERVICES IN TRANSITION
WORKING PAPERS

4

Designing local processes for service development

SU KINGSLEY and DAVID TOWELL

Introduction

This is the most important of our working papers. Drawing on our experience of work with managers and professional staff (NHS, local authorities and voluntary agencies) from over a third of the local services in England and Wales, it is our contention that the development of decent quality services is only likely to be achieved where attention to the design of these services is complemented by equivalent attention to the *design of the process of service development itself.* In this paper we set out to describe and illustrate a model of service development which can provide the basis for a wide range of local efforts to make effective progress.

Any examination of the changes in psychiatric services in different parts of Britain over the last decade or more would of course show considerable variations in both the pace and nature of local development. At best there has been some growth in good quality services, often quite small in scale, which reflect the energy and ability of local innovators. However, the current context is one in which incremental growth is being overtaken by pressures for more rapid and large-scale changes, particularly those associated with the decentralisation of NHS institutional provision.

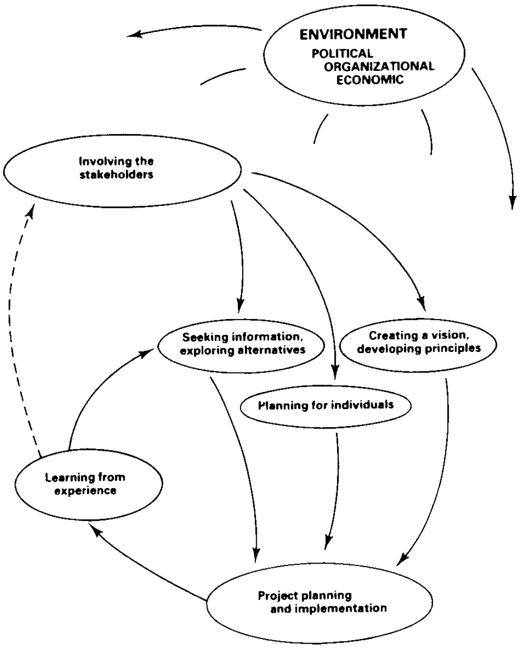
These pressures present a period of opportunity, and a period of risk. As both the House of Commons Social Services Committee[1] and the Audit Commission[2] have argued forcibly, the national strategic framework and financial policies within which change is occurring are far from adequate. The recent review of community care policies by Sir Roy Griffiths reinforces this view.

There is also considerable evidence that weaknesses in traditional approaches to planning and implementation at local level may mean that opportunities for improvements in services will be wasted.[3]

Where improvements occur they often appear to rely heavily on the efforts of one or two key individuals: this has created difficulties in spreading and sustaining changes. These 'innovations' frequently fail to fulfil their potential for changing services on a larger scale. However, in those cases where broader shifts are being achieved it is apparent that the local context for change provides fertile ground for leaders to work in. This suggests the importance of persevering at change, rather than depending on charismatic individuals; it also suggests that the significant strategic objective should be to build and support the local capacity for achieving informed change.

Planning is commonly construed as a set of activities, organised in a sequential series, which leads rationally to a fairly predictable outcome. However the experience of planning psychiatric services frequently fails to match this model, leading to a sense of failure and frustration among the participants. Moreover, and even more seriously, planning failures either stunt the development of new services, or create replacement services which repeat previous patterns of provision in new sites.

Figure 1 Elements in an organic model of service development



We hope to show that there are alternatives which can best be sought through looking at *how* planning takes place – the 'process' – rather than at *what* is planned – the 'product'. In particular we suggest that planning should provide ways to involve all those with an interest, or 'stake', in local psychiatric services, albeit in different ways: front-line staff as well as planners and managers; local authorities and voluntary organisations as well as the health service; service users, their families and the communities among whom they live, as well as professional service providers. What we have written here about designing the local development process will be relevant in different ways to all of these groups.

Our approach to planning and implementation described in this paper seeks to integrate the process and content of service design to create an organic model of service development. Its major themes and their inter-relationships are illustrated in Figure 1. The Figure seeks to represent planning as a number of overlapping activities which require regular review and revision. It includes six main elements:

- commitment to involving a broad range of *stakeholders* in the future pattern of psychiatric services by contributing their expertise and experience to the process of service development;
- stress on the importance of planning for *individuals* and therefore developing methods for directly involving service users in this participative approach;
- recognition that the development of high quality services must start from clarity about the *values and principles* which define quality and be guided

by a shared vision of what would constitute a desirable future;

- investment in a variety of *information seeking* activities designed to map potential demand, increase awareness of how services impact on individual users and explore alternative ways of meeting needs which will be consistent with these principles;
- recognition that plans and practice need to be revised and reformulated through *learning* from the experience of implementation;
- careful attention to the way all these activities can be incorporated into the *formal decision-making* structures of the larger public agencies (particularly the NHS and local authorities) responsible for providing local psychiatric services.

This process needs to be dynamic. The challenge of planning for new patterns of services is to go beyond existing and known forms of provision. This will require a robust framework for dealing with and adapting to changing circumstances, while always maintaining a clear end in view.

In elaborating these ideas we have emphasised the development of services to meet the needs of adults with severe psychiatric disabilities. This description gives particular attention to the features of the model which are not common in much current practice, beginning with the importance of seeing planning as everybody's business.

Involving the stakeholders

Health service development has traditionally been led by professional interests, although this has been extended since the 1974 reorganisation to include key service managers, the 'corporate rationalisers', who have a broader focus on the overall provision of services.[4] Designing major changes in the pattern of service delivery needs to involve a much wider group of interests – including both providers and recipients. A series of questions may be helpful in identifying representatives of these broader interests.

Who has a legitimate concern with the future pattern of psychiatric services? As the situation changes, who will be able to influence decisions?

Who stands to gain?

Who stands to lose?

In a group considering community mental health centres, a response to these questions produced a list of seventeen agencies including the Samaritans, local housing offices, a counselling agency, service users, various groups of professional service workers, mental health voluntary organisations, health authority members, relatives and carers groups, and local branches of national specialist agencies.

Other groups considering different aspects of psychiatric services are likely to produce lists with a similarly wide range of interested parties. Traditionally many of these agencies have been excluded from important decisions concerning service development, although their contributions are potentially very valuable. They represent a wealth of interest and energy which creative planning can harness. In particular, people who are current and past service users, relatives and carers, and front-line staff, have perspectives on the ways in which services are delivered, but have not generally been involved or consulted in the development of new services.

In planning community-based services, where success will depend on the support of a network of groups and agencies with no single body in overall control, building shared commitment at an early stage is essential.

Mobilising multi-agency groups

The starting point for creating wider service development networks can vary. Where major developments are concerned, however, it is important that a core of senior managers is at the centre of these networks (like the joint planning groups suggested in the Nodder and MIND[5] proposals) who can integrate planning with the formal decision-making structures of the NHS and local authorities. Such collaboration is more likely where authorities have made commitments to a joint approach, reflected for example in agreeing to pool financial resources in a programme budget for mental health services. As the voluminous literature on joint planning suggests, this commitment will have to be carefully built up in the face of extensive obstacles.[6]

However, participative planning requires much wider involvement. In North Lincolnshire Health Authority, for example, a group of 23 people from all levels of the service, and including service users, relatives and informal carers, was brought together to generate designs for a future service.[7] The wide membership meant that it encompassed a much broader range of backgrounds and experience than is common in planning groups and much greater attention had to be paid to how the group worked together in order to ensure that everyone had an equal opportunity to take part. Another example of joint action between different agencies comes from the Coalition for Community Care, a voluntary group initiated by three CHCs and their local MIND associations in west London. The aim of the coalition is to focus attention on the need for joint strategies for mental health service development in an area where joint working has been severely handicapped by overlapping geographical boundaries and unclear responsibilities. The coalition now has members from the local statutory providers as well as concerned individuals, users and ex-users of mental health services, and other voluntary groups. It has become an important neutral meeting ground where perceptions and ideas can be shared between groups with diverse backgrounds and interests.

The size of these groups is of course a challenge in itself. Working in a group of 30–40 people requires new techniques and is a very different experience from the small committees found in traditional service planning. Meetings need to be carefully organised, with small group work and well managed large group sessions, to ensure that everyone has the opportunity to participate. Larger groups are also likely to bring in people who are unaccustomed to committee procedures and who may need specific encouragement in order to participate fully. There are already a number of examples which illustrate how large planning groups can work effectively. We have ourselves worked, for example, with agencies from the London Borough of Islington in structuring participative events for 100 people – helped by the availability of the Fund's well-designed conference facilities. In North Lincolnshire, too, an external facilitator was brought in to design a process by which a large group could work together. The group used an exercise which enabled them to agree on some common guidelines for service development. They then split into smaller task groups of 4–6 people to work on detailed proposals for developing particular aspects of the service. These proposals were brought back to the whole group for approval before being put to the district management team. Coalition for Community Care and forums in Lambeth, Islington and Lewisham have all been helped by paid workers who, in addition to doing administrative work for the group, arrange a programme of meetings, sometimes with outside speakers or leaders, providing opportunities for those invited to think through major issues.

Alternatively, a group which starts from a small core may draw in local expertise by setting up a series of sub-groups around specific topics, each of which then creates a new nucleus attracting other people. This cascade or pyramid system has been used successfully in places where districts have identified localities as a basis for service planning and delivery.

Community participation

Bringing local community representatives into service planning is a much more challenging task than bringing together different professional agencies. We have little experience in Britain of community participation to fall back on and what we do have often looks like empty tokenism. (For example, the lone consumer whose voice is swamped and confidence undermined in a committee of experienced professionals.) Yet there are good reasons for extending participation to the community, as illustrated by Exeter's experience of 'locality planning'.[8] By contributing their knowledge and expertise, local people can improve the quality of service planning and help to make maximum use of available resources. Participation in planning can ease implementation by engaging with divergent views at an early stage and channelling conflict into productive activities. Local participation is an important way of ensuring that planning groups receive early feedback. Finally, since community care must also be about desegregation it demands an active involvement from the community, not simply passive acquiescence.

It is important here to start by thinking small. Traditionally the smallest unit for planning in the NHS has been the health district – with a population of between 150,000 and 500,000 in an area ranging from a crowded few square miles in an inner-city, to rural districts which stretch 50 miles in one direction and 40 in the other. The trend towards decentralisation in social services and housing departments has demonstrated that the areas with which local residents identify are much smaller, usually of between 5,000 and 10,000 people. In the NHS, this trend is also evident in recent changes in primary health care, particularly the shift towards 'neighbourhood nursing' recommended in the Cumberlege report. Further, as interest has grown in coordinating the efforts of statutory services with voluntary agencies and informal carers it has become evident that this is more feasible in a small locality. So in planning the future pattern of mental health services there is much to be said for seeking ways to develop planning based on neighbourhoods and small localities rather than planning which attempts to suit the blanket needs of a whole health district. At the same time, experience in social services decentralisation has shown the importance of a framework of specialised services, providing support to local services and actively liaising between local and district-wide services. People with continuing care needs are likely to be especially vulnerable to isolation and consequently may be overlooked by services not charged specifically with ensuring that their needs are met.

Experience in Exeter and elsewhere suggests ten preconditions if community participation is to be productive:[9]

(i) local people should be viewed as a resource, with innovative ideas for meeting needs, not simply a source of additional demands;
(ii) the community's concern to develop an appropriate local service should be respected – it is in the community that mental health problems arise and most people even with severe psychiatric disabilities are already living outside hospitals;
(iii) participation should be an opportunity for local people to influence plans and priorities, not merely a public relations exercise in disguise;
(iv) local views and questions need to be taken seriously – naivety may be a result of lack of information, but can also point to fundamental issues which sophisticated approaches have glossed over;
(v) localities need to be defined on the basis of subjective experience rather than administrative convenience;
(vi) participation demands an informed public which means that local people will need access to information and education;
(vii) initiating community involvement is likely to require an informal or personal approach, building on local leaders and networks: formal meetings are not enough to overcome a long history of people being excluded from decision making;
(viii) for the same reasons, persistence will also be required, and appropriate administrative support which avoids bureaucratic procedures and professional jargon;

(ix) effective participation requires genuine dialogue and demands that professionals learn to listen to local people;

(x) finally, success breeds success – first steps in participation need to be built round projects where visible outcomes are likely to be created sooner rather than later.

Working with conflict

Bringing many different 'stakeholders' into a single planning forum will introduce significant differences in interests, perspectives and ideologies. Indeed, making conflicts explicit at the planning stage is an intentional part of the strategy to avoid plans being undermined during implementation.

Planning a future service which depends on involvement by a broad spectrum of groups means that differences need to be recognised and understood. Small planning groups often function quite comfortably because they have excluded dissenting voices. However, the price of this exclusion is subsequent opposition. There seems much to be gained from identifying and exploring differences at an earlier stage in the process.

Conflicts are often embodied in the varying perspectives which derive from different therapeutic models. The classic expression of such conflicts is the difference between the 'medical' and 'social' models of distress, epitomised by tussles between doctors and social workers.

Some of these conflicts relate to fundamental differences in approach to people with long-term psychiatric disabilities, their 'human nature' and the place they deserve to take in the world. Underlying these differences, however, may be other agendas which arise from the particular interests of different groups of providers and their relative influence in changing the pattern of services.

Among the professions represented in psychiatric service teams, doctors have long been recognised as having a legitimate role in service development. As services move away from medical focus and into a more social arena, other professional groups – psychologists, social workers, occupational therapists, community nurses – come to play a more central role and begin to assert rights as independent practitioners. Involving voluntary groups – consumer representative bodies like CHCs and service users themselves – presents a new range of challenges. There are no easy ways to resolve these conflicts. A first step is to recognise them. A second step may be to identify areas of shared aspirations and areas of difference, and to accept that differences may form the basis of alternative approaches.

Bringing in service users

Users are key stakeholders in planning and providing new services. Participative planning provides a major opportunity to increase the contribution which they make to decisions about future patterns of provision and the tailoring of specific services to their needs. Individuals do not fit neatly into service packages, particularly where rigid boundaries exist between organisations and professions. Breaking out of conventional patterns of thinking can generate a range of alternative ideas for future services; one way is to use individuals and their experiences as the focus and starting point for planning new services.

A persuasive example of the way in which plans changed when individual needs became the focus is provided by a 'getting to know you' exercise carried out with five elderly men, each with a long history of residence in a large psychiatric hospital.[10] Working backwards from detailed knowledge of the five men, rather than forwards from their place of residence, suggested that they would be better suited to a group home than the local authority 'Part III' home suggested. This was by no means a revolutionary solution and did not require a major re-think of local service provision. What the exercise did do was challenge the conventional assumptions held about the men and, by getting to know them, open up other service options better suited to their needs.

While starting out by considering individual needs can be a source of creative tension it has also led to frustration and feelings of impotence in other situations. Anyone intending to design a service development process around individuals should be aware of three key points. First, concern to meet individual needs must be rooted in a set of values and principles, established and agreed locally, which can subsequently provide reliable guidelines for the practical stages of the project. Second, the methodology needs to be well planned in advance in order to sustain activity and provide a means for organising and sharing complex information. Third, long-term success can only be achieved through ensuring that innovative projects like this are integrated into the formal planning machinery.

As *Changing futures*[11] describes in more detail, people involved in other 'getting to know you' projects have devoted considerable time to familiarising themselves with the day-to-day lives and histories of small groups of mental hospital residents, identifying similarities and differences in their experiences, and their ambitions for the future. Using concrete terms and everyday language for these descriptions enabled staff and volunteers to get beyond the restrictive categories of existing service provision. This helped the groups to consider very specific needs; rather than thinking in terms of 'dependency levels' they spoke of needs for food, shelter, friends and so on. Moving on from specific individual needs they were able to hypothesise a range of alternative service designs. From these they drew out the service framework which needed to be created in order for people to leave hospital and resume their lives in the community. Similar approaches are equally important in the design of services to support people with psychiatric disabilities already living in the community.[12]

Again, *Changing futures* describes in detail how service users can be brought into the planning process in a number of different ways. They may be asked to participate directly in a service planning group; their views may be represented through a user group; advocates could be appointed to seek out and represent service users' interests; their views and experiences can be sought through interviews and discussions.

The most developed forms for such participation are probably to be found in the Dutch 'patients councils' (see Working Paper 6) but there are a number of modest British innovations – for example, the Nottingham Advocacy Group, the Camden Mental Health Consortium and the North Derbyshire Mental Health Services Project – and the beginning of some larger initiatives to make users' views central to service development, notably in the Birmingham Community Care Special Action Project. In addition to these direct methods, there are numerous published accounts, collations of users' experiences of the mental health system and some videos, all of which provide an important stimulus for change.[13]

Developing a vision

If these participative methods are to be used to go beyond the familiar pattern of planning which merely reproduces old services in new places, a continuing investment will be needed in creating a shared *vision* of future services as a basis for subsequent action. Visions are not blueprints: rather, they entail seeking agreement on the values and principles which should underpin service design and starting to sketch the forms of provision most likely to ensure that these principles are realised in practice. Such principles need to be concerned with both the experience of the service as it will be delivered, and with ensuring the conditions for such a service to flourish. They also need to encompass both individual and community interests in the service. (See Table 1)

There is an increasing number of sources from which principles for psychiatric service development can be drawn. Of particular interest is the MIND document *Common concern* and the work on normalisation which is increasingly being adapted from its North American origins to fit a UK context.[14]

An excellent example of what is involved in developing a principled framework for change is provided by the work of our King's Fund colleagues on services for people with dementia. Drawing on

Table 1 Some principles defining quality in psychiatric services

	PROVISION	OUTPUT
FOCUS ON:	Conditions for quality service development	Ensuring quality experience for users
The Individual	● Clear service principles ● Focus on individual needs ● Multi-agency network ● Stakeholders involved in development ● Support and training for staff ● Evaluation and review process	● Presence and participation in community ● Individual programme to meet needs with continuity ● Access to appropriate professional help ● Opportunities for personal development and choice ● Protection of rights and citizenship ● Enhanced self-respect, reduced stigma
The Community	● Adequate specialist resources ● A range of general community services ● Capacity to check for unmet and new needs ● Value for money – economical delivery	● Comprehensive services meeting a range of needs ● Meets priority needs and needs of different groups ● Provides access to primary and specialist care ● Accessible, available when and where needed ● Community education to reduce prejudice ● Supports unpaid relatives and carers

the experience of a multiprofessional group concerned about elderly people, they were able to agree the five key principles for these services summarised opposite. *Living well into old age* draws out the implications of these principles for individual users, for front-line staff and for managers and planners.[15] In *Changing futures* our colleagues have undertaken similar work in relation to the resettlement of people from long-stay psychiatric hospitals and describe in detail the pattern of housing and support services which may be expected to follow from the vigorous application of a principled approach.

However, service principles are only likely to have a significant impact on policy and action if the development group itself has been involved in identifying those principles to which they are committed locally. There is a variety of procedures for doing this, the most powerful of which starts from the experiences of service users. An exercise for large groups which has been developed for King's Fund workshops asks the group to identify from users' experiences of current services those experiences which they would like to see more of, and those that should be avoided. Common aspirations are then grouped together and from them generalisations are drawn in the form of principles. An alternative approach, also based on the idea of users' experiences of service provision, adopts a card-sort technique to identify service goals and the principles underpinning future development.[16]

Exploring the principles which could form a basis for future services brings out fundamental differences and identifies areas of common ground. Our experience is that the common ground is often broader than anticipated – areas of disagreement about how services should develop have often obscured common aspirations for the service. In particular, ideological differences about the nature, appropriateness and qualitative experience of different therapies have masked agreements about the quality of everyday life for people with psychiatric disabilities.

Generating principles provides the basis for further detailed work. In order to use them in developing the service it will be necessary to consider how different aspects of the service will operate in order to reflect the principles, and to write operational policies which express this at the level of daily practice.

Planning from the vision

Charismatic leaders are often people with a clear and influential vision who, to change reality or create an organisation to deliver the vision, have to find ways of translating the long-term goal into short-term steps and activities.

Traditionally, planning groups have worked forwards from their present position, asking at each stage 'and then what happens next?'. This method assumes that the route as well as the destination are known, or at least can be known, and the task is simply to identify the best path (hence the fashionable 'option appraisal'). Consequently the focus for planning is on means rather than ends. By contrast, the path is uncharted in attempting radical changes; each step needs to be invented as we travel and the destination is often obscure. A 'vision' of how the future service might look provides a marker for our destination. The question which can then be asked is: 'and what conditions should prevail for this to become the case?'. In this way, questions about the products of planning can be raised continually. 'Backward mapping' is a technique which progressively identifies the elements which enable these outcomes to be achieved.[17] Starting with the ultimate goal and working backwards to the present position, each step back generates a new intermediate objective. This provides a skeleton chart of targets to be achieved along the way. Then, looking forwards, an action framework can be identified.

An example may make this procedure and its application clearer. In Hackney the psychiatric service experienced a shortage of acute beds some years after admissions to a distant long-stay hospital had ceased. It was found that patients were remaining on the acute ward because there was no alternative accommodation for them. These patients were of different ages, experienced different conditions and had different requirements. To solve the service problem and to improve the patients' experience a choice of alternative accommodation, together with appropriate support services, was needed. A range of different sorts of housing had to be identified and made available. Finding the housing would mean developing links with a number of agencies providing accommodation, and identifying the direct provision which might be available. Developing links would require skill and a considerable investment of time: consequently the first step was to get approval for a new post of housing development officer. The planning, however, had not started by funding a new post, but by considering key issues that offered potential for improvement in the patients' lives.[18]

'Backward mapping' identifies who or what needs to be changed 'close to the ground' in order to achieve the desired outcomes (and therefore what interventions, incentives and innovations will be needed to promote these changes) rather than relying on the lengthy chains of consistent decision-making required for the implementation of policies from the 'top' downwards in large, bureaucratic systems.

Making the most of creativity

Since no single correct answer to the provision of future services can be uncovered by a technically competent search, it will be important for the planning group to spend time generating and exploring alternatives and possibilities. Exercises which do not produce an immediately practical result are often seen as 'time wasting' and consequently avoided by planners and practitioners. Their value lies, however, in the opportunities they offer to consider new approaches. Looking at alternatives brings fresh ideas into a group and helps to develop its ability to work creatively.

Principles from *Living Well Into Old Age*

Principle 1

People with dementia have the same human value as anyone else irrespective of their degree of disability or dependence.

People who do not work and people who have serious disabilities risk being undervalued in our society. Women, too, are often undervalued. Since many people with dementia fall into all three categories, they are at risk on all three counts. Expectations about quality of life for people with dementia must not be allowed to fall below the standards of other members of the community. Services should be concerned not just with meeting minimum standards but with positively demonstrating the value and importance of older people with dementia.

Principle 2

People with dementia have the same varied human needs as anyone else.

This means not only basic needs for food, warmth, shelter and protection from physical hurt, but also for affection, companionship and opportunities to take part in worthwhile activities. They are entitled to share in the whole range of life's experiences as other citizens do, alongside other citizens in the mainstream of society. Only when they live as others do can people with dementia be accepted as having equal value. Only by living as others do will they have access to the same range of human contacts and resources. What we are aiming for here is not simply living in the community, in the sense of living outside a residential home or hospital or being cared for by the community without access to proper help from professionals and services; as we see it, real 'community care' implies being cared for as a member of the community. To achieve that objective for people with severe dementia and to help them enjoy some of the benefits of community life will require a high level of long term support, professional skill, imagination and resources.

Principle 3

People with dementia have the same rights as other citizens.

People with dementia are often denied their rights and the opportunities and resources to which they also have a right. In many cases, they are unable to assert their just demands on their own behalf. Where people with dementia do not themselves have the ability to claim their rights, it is the duty of those who serve them to find alternative means to claim on their behalf and to preserve their rights jealously. When formal steps are taken to change the legal status of an individual the safeguards and access to representation should be to the highest standard expected by other citizens.

Principle 4

Every person with dementia is an individual.

People with dementia, like anyone else, have the right to behave as individuals, within the limits of the law, and to be seen as individuals with their own preferences, abilities and needs.

One part of individuality is being helped in ways that are personally tailored to you. A second part is making sure that your individual history and past life are not lost and forgotten by those around you. Individuality means having continuity between your past, your present and your future.

Principle 5

People with dementia have the right to forms of support which don't exploit family and friends.

It is the informal support of families, friends and neighbours which provides the major proportion of help for people with dementia. These carers have the right to expect a normal quality to life, without being exposed to stress and exhaustion. Those providing services have a duty to ensure that they actively recognise and support the work carried out by carers.

There are situations in which the needs and wishes of the elderly person conflict with those of the carers. Services should be concerned that both parties' rights are safeguarded.

Alternative approaches to service provision can be identified in various ways. We have already described one powerful procedure – that of identifying the needs of individual service users through 'getting to know you' exercises.[19] Services and projects in other places can also provide useful ideas. The Good Practices in Mental Health information service, for example, has accounts of innovative psychiatric service initiatives all over the UK. They are currently collating much of this material into packs focussing on different examples of the provision of specific services (for example, housing, advocacy and alcohol services). These include a statement of key service principles and a brief introduction to important issues (See Working Paper 7). GPMH is also able to call on its information base for examples relevant to particular client needs – for instance, ways of providing longer term community support. One point which GPMH stresses is that projects cannot simply be transferred or replicated in a new site: a different local context will require different strategies in order to achieve similar outcomes.

Looking at alternatives can also be stimulated by criticising and making recommendations about existing plans. Again, establishing principles for service development provides a firm basis for looking critically at current proposals. If the planning group has established a set of principles like those set out in Table 1 and the example from *Living well into old age* we would expect to see serious alternative proposals emerging which are able to coordinate different elements of provision around individuals' needs rather than focusing on each element in isolation. They would be concerned to develop the service mainly through supporting staff and enhancing skills, rather than by providing buildings.

Seeking information

A major source of failure in conventional planning for future provision is the assumption that individual needs can be met through services designed on the basis of information about populations. Consequently, people who need specific forms of help – for example, support in daily living – are slotted into mass produced packages on a 'take it or leave it' basis. One of the most immediate problems faced by people leaving hospital is finding accommodation, and housing is an aspect of community care which has received great attention. However, simply being housed in the community is not enough for an acceptable life. The person who lives alone may require help with shopping and cooking; will be unused to housework; probably needs encouragement to go out, and someone to go with them – at least until the other members of the club or centre are familiar. Such help might be provided by a coordinated combination of home-help, CPN and social work services, and voluntary support. What is essential is that the service development process is sufficiently sensitive to address this variety of needs for *each* individual. Planners and other participants in the design process will need different sorts of information gathered from a variety of sources and using a wide range of methods.

Broad parameters for a local service can be developed from assumptions based on research and epidemiological data.[20] These provide annual estimates of how many people are likely to suffer from dementia, to become severely depressed, to experience a psychiatric episode or to have other psychiatric problems requiring major assistance. In the same way information about current patterns of service use can be employed as rough indicators of likely patterns of need.

In addition to generating information about the aspirations and principles which will inform service development, planning groups should be clear about constraints, particularly limits on the financial and human resources. There are alternative resources which might be brought in to supplement the service. These include additional finance (housing corporation funding and payment by clients themselves from supplementary benefit entitlements, for example) and facilities – leisure centres, adult education provision, voluntary groups and so on.[21] Elsewhere, (Working Paper 5), we have emphasised the importance of designing a strategy for relocating patients from large hospitals which pays attention to both the statistical parameters of the patient population (age, sex, borough of previous residence, estimated functional capacity and so on) and detailed individual needs for services (specific abilities and disabilities, friendships, patient's preferences). This requires two distinct stages of information gathering and assessment. Firstly strategic planning in which the framework of different agencies and services is created; and secondly project planning meeting individual needs of particular patients.

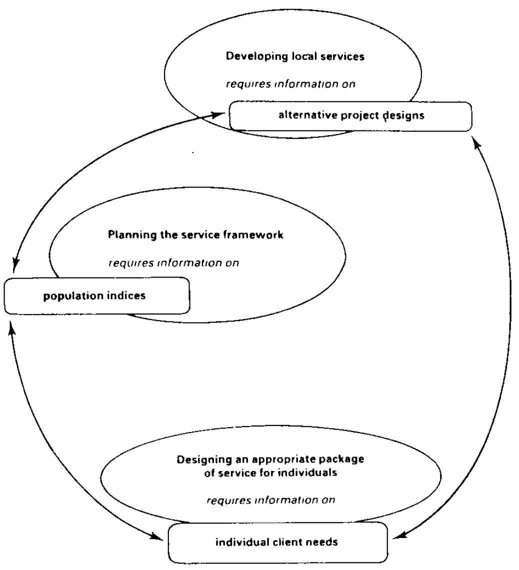
Similar distinctions will need to be drawn in developing other local services. It is not sufficient to design services for individuals on the basis of broad categories of need derived from whole populations. Nor can services which adequately meet the spread of different needs found within a population be developed entirely on the foundation of the needs and experiences of existing service users. Indeed, in service planning there may be three main targets for an information gathering strategy: individual experiences, project design and population indices. The first, individual experiences, can be achieved by creating service packages for individual users, based on information about the needs, experiences and ambitions of particular individuals. These 'packages' are likely to include elements drawn from the different projects that make up a district service. The second, project design, will require ideas from other districts about how similar services have been set up, as well as (and as a stimulus to) creating local visions of the future. Population indices are necessary to ensure that the service is capable of meeting the range of needs across the district, to provide a basis for assessing priorities and to ensure that questions of equity are addressed. They include information about the size, age and ethnic structure of the population, and the incidence of needs for service in the district and in other similar populations. The process of service design will need to ensure that each level of information is scanned and rescanned as development progresses (see Figure 2). As we argue more fully later, information is also vital to quality assurance and the more general need to learn from experience.

Linking planning and implementation

A further weakness in traditional centralised planning methods which our approach is designed to overcome is the disjunction between planning and implementation. 'Top down' planning is vulnerable to alteration of purpose as middle managers and providers adapt the planners' ideas while putting them into practice. Planning divorced from implementation also fails to make use of a most important resource – local practitioners who often have a wealth of good ideas for service development and ways of meeting specific local needs which do not figure in central planning assumptions.

As we noted earlier, locally-based staff may know of underused community buildings and small-scale voluntary associations that could usefully contribute to support services for at least a few local people.

Figure 2 Information for planning a new service



Involvement in planning strengthens the prospects for effective implementation. It also provides an immediate test of whether intentions are being realised as different aspects of the service are developed.

For example, progress was held up in one north London district by initial failure to involve front-line staff in plans and consultation for change. This meant that the region's proposals to close a large hospital lacked credibility and were not taken seriously. Staff who had not thought through the issues of service development saw new ideas as 'pie in the sky'. It has taken a long time and much hard work to move away from this position and to develop a climate in which change is possible. Many staff in the psychiatric service have a long experience of radical proposals that are frustrated by practical realities, which increases their scepticism. Without their commitment and energy, major service changes will be impossible. The most that will happen is some shift in the site of service delivery, with little change in philosophy or style.

Learning from experience

Planning for change recognises that the future, although guessable in some respects, always involves uncertainty. It is not like a simple puzzle which application will solve. Service development should be a continuing process of generating and testing ideas, with review and feedback mechanisms built into it as key features.

There are numerous ways in which the experience of development can be used as learning for subsequent initiatives. Creating a task force which identifies problems and possibilities and has resources to try out some local solutions, is one way to link planning, implementation and review. Another way of creating energy and harnessing enthusiasm is the use of 'vanguard projects', or 'vanguard areas'. Identifying an area or aspect of the service in which a new approach can be tried is one way of testing the approach, and offers valuable learning about the problems of implementation locally. In this way a district might try out some new ideas without risking full commitment in an uncharted area.

Learning can also be fostered by systematic investment in performance review. Principles have an essential role in monitoring and evaluation by creating standards against which the service can be assessed. It is of course vital that monitoring leads to change where necessary, further reinforcing the importance of gaining broad commitment to the directions and development of the service. Setting standards requires careful consideration from various points of view of the different ways in which principles may be put into operation. Thought must be given to the individual service user, the project and the district service as a whole. For instance, a service wishing to enhance the rights and citizenship of people with psychiatric disabilities must ask different questions at different levels of its 'system'.

At individual user level the focus might be on the ways in which patients' money is dealt with; at project level, on what attention is paid to ensuring that people on welfare benefits receive advice and help, and that service users are aware of mental health legislation that affects them. At district level it might be important to support project activities with an advice and advocacy service. District should also ensure that effective procedures are established to gain access to the Mental Health Act Commission tribunals, offering representation where necessary.

Such activities depend on the development and maintenance of appropriate information bases. There is little experience in psychiatry in keeping routine information, apart from hospital case notes, although there are examples of psychiatric case registers in Camberwell, Nottingham, Salford, Waltham Forest, Hackney and Southampton. Case registers aim to track all patients across a service or a district, providing a continuing record of their psychiatric state and their contacts with services.[22]

Information which can be used to monitor the extent to which a service is fulfilling its aims can be collected in other ways. Interviewing users to find out the extent to which the service is meeting their needs is a valuable exercise; the views of relatives and carers can be equally valuable. User surveys which concentrate on the past are valuable in determining which group or groups are making most use of the facility and whether the service is reaching its intended target group. Identifying other agencies likely to be used by a particular target group and discussing their views of how related services are working is also usually illuminating.[23]

When establishing quality assurance procedures as a means of sustaining service standards it may also be necessary to identify priority questions for attention. In particular, when resources for review and evaluation are in short supply it is important to concentrate on the quality of service provided for those clients who are least 'attractive' and consequently most vulnerable. These include people with long-term needs who demonstrate little enthusiasm for personal growth; elderly people, especially those suffering from dementia; and minority groups (for example, from the black and ethnic minority population) where the challenge is to rethink existing services to respond to different experiences and perceptions. There are clear warnings from other countries, especially the USA and Italy, where reform has neglected some of these groups. Failing to respond to their needs has seriously undermined the strategy.

Putting psychiatric service planning in context

All planning activity occurs of course in a wider political, organisational and economic context which shapes both the processes of change and the interests which are likely to be most influential. The model of service development we have described needs to be situated in the administrative context of established decision-making arrangements in health authorities and local authorities.

As we argue more fully in Working Paper 3, it is especially important that creative processes of development are linked to the formal planning and resource allocation procedures of the public agencies. While these procedures may not seem to be the best way to plan for major changes they are the keys to action. Service principles will need to be developed while resource bids are being made – especially in areas where long lead times are typical. There may be either dialogue or struggle with managers who have to allocate resources across a wide range of service areas. These exchanges should indicate the resources likely to be available and may be useful when negotiating the nature of the service and the volume of resources with higher tiers of management. Political allies, identified and fostered at an earlier date, will be valuable at this point. As well as linking activity up and down different tiers of the same agency the development process needs to take account of planning being carried out in parallel – in large institutions, in local authorities and in the voluntary sector, for example. Because services are interdependent, planning must find ways of recognising mutual impacts and create a continuous process of mutual adjustment.

Inevitably the implementation of new services will also require the identification of priorities: these might take the form of experimenting with new types of provision focusing on underserved groups, or developing high quality services which could provide a model for subsequent initiatives.

Financial advice from treasurers and others responsible for regulating the resource framework will be vital. Funding new services is increasingly becoming a sophisticated entrepreneurial task, both because of the need to develop policies which enable funds to be shifted from old to new services (including various 'bridging' arrangements) and because of the increasing dependence on dispersed sources of funding for the psychiatric service budget (including the NHS, local authorities, housing agencies, the Manpower Services Commission, social security and special government project initiatives).

A further important component in the wider strategic framework which influences the process of service development are the manpower and staff development policies established by the NHS and local authorities. In many areas, manpower plans and training strategies are being formulated which are at best only loosely associated with the kind of detailed service planning we have proposed. If these processes remain separate, staff support for change is likely to be undermined and the implementation of new services damaged by the lack of trained staff. Service planning coordinators should maintain a continuing dialogue with personnel managers about the staffing implications of emerging plans and ensure that a significant investment is made in training and support for the people who will be delivering the future services.

Conclusion

Meeting the challenge of creating effective community-based services will require commitment and imagination. Others have described cogently what this might mean for particular aspects of local provision.[24] We have tried to develop a framework of ideas about the process of development which we believe has a greater chance of producing genuine community-based psychiatric services than the traditional approaches to planning distilled through bureaucratic structures. Working through the complexity of existing organisations and systems, we have argued that service development requires a continuous process of

- building networks of concerned people;
- developing shared views of the present state of services and the trends which will bring about future changes;
- creating shared images of desirable futures for individuals in the light of a real appreciation of their current life experiences and their own views of what they need;
- identifying a wide variety of constructive actions, large and small, which people in these networks can undertake to increase the prospects of realising these desirable futures.

We have also argued for a dynamic approach characterised by a commitment to learning about better ways to plan and manage services, about the impact of services on the individuals and communities they are designed to serve and about the potential of people with serious psychiatric disabilities when given appropriate opportunities and support.

All this has impressive implications for the exercise of leadership. As we see it, leadership is an important responsibility of people with senior managerial and professional roles, but it can and should be fulfilled by many people at different levels and in different parts of local agencies, where possible working together to generate a coherent impetus for change.

First and foremost, leadership is required to orchestrate the new vision of future services and promulgate clear messages about the rationale for change. Leaders need to demonstrate through their own behaviour their dominant concern with the impact of their decisions on the lives of people with psychiatric disabilities.

Second, leadership is about gaining and maintaining support for the implementation of this vision. Looking 'upwards' and 'outwards', it is about building an authoritative mandate for change and mobilising political commitment to making the necessary resources available. It is too about coping with environmental pressures and uncertainties in ways which keep a clear sense of direction in the mental health services. Internally it is also about building widespread support while accepting doubts, encouraging constructive debate and providing assistance to people in working through the conflicts involved in achieving change.

Third, effective leadership needs to be based on the premise that successful development and delivery of good quality services requires a wide variety of action, particularly of course at 'street level' where providers and users meet. Leadership is important therefore in organisational development – creating and protecting the conditions which enable and support the work of operational staff.

Fourth, leadership is about making change 'stick'. Innovation is rarely achieved once-and-for all: it has to be maintained over time in the face of the many pressures which can undermine the original goal and be renewed continually in the light of fresh ideas and opportunities. Leadership is required to ensure that new ways of organising and delivering services are supported by the wider policies and procedures in the agencies involved. It is also important in establishing explicit forms of accountability for performance and appropriate quality assurance arrangements.

Fifth, leadership has a critical role in developing the commitment and capacity for organisational learning. It must maintain an overview of progress towards key objectives, identifying the unsought consequences of good intentions and enabling mid-course corrections to be made. It should encourage opportunities for sharing successes and learning from what is being attempted elsewhere. Finally leadership must face up honestly to the limitations of current achievements and mobilise support for the continuing struggle to do better.

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MANAGING PSYCHIATRIC [illegible]

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MANAGING PSYCHIATRIC SERVICES IN TRANSITION
WORKING PAPERS

5

Assessment, rehabilitation and resettlement

Designing the arrangements for moving people from psychiatric hospitals into local services

TOM McAUSLAND, DAVID TOWELL
and SU KINGSLEY

Introduction

In the preceding papers we provide an overview of key issues in managing the relocation of psychiatric services from large institutions to new patterns of local provision. Elsewhere ('Moving out from the large hospitals' in Care in the community – keeping it local. MIND Publications, 1984) we discuss ways of involving staff and patients in this process of transition. The notes that follow deal with another aspect of managing transition in more detail and offer a summary of our thinking about the characteristics of an assessment and resettlement model which would be compatible with the wider planning processes set out in the earlier papers.

We will be particularly concerned with two questions:

(i) How can senior managers and planners make use of information about the needs and capabilities of people currently living in large hospitals to improve service planning?

(ii) How can the overall task of moving large numbers of people out to local services be broken down into manageable stages so that the resources for rehabilitation are used efficiently and the interests of individual patients are safeguarded?

Our starting point was consideration of appropriate techniques for inpatient *assessment*. It soon became clear however from discussion with people in the field that what *is* appropriate depends very much on the stage that has been reached in developing local services and the type of planning activity that is involved.

On a strategic level, 'receiving' districts and local authorities trying to establish broad parameters for planning local services need information on the approximate number of hospital inpatients who will require services (taking into account likely deaths over the expected transition period) and basic data on age, sex and estimated functional capacity. 'Providing' districts with responsibility for the management of the hospital during transition require the same sort of data for their coordination and monitoring tasks. These planning groups do not need, and do not have the capacity to cope with, highly detailed information from profiles of named individual patients. For broad brush planning activities (for example, deciding the relative allocation of resources to user districts; giving a picture of numbers of people each district is planning for) general statistical data which can be obtained from existing hospital records, supplemented by information from staff on the wards, is probably adequate.

This sort of information is not sufficient for detailed service planning, such as producing operational policies for community dementia teams or deciding the form of local residential provision. These depend on more sophisticated information about patients' capabilities and needs. They will require substantial input of professional time and expertise, and must provide opportunities for patients themselves to contribute their experience and preferences as part of the service design process.

Therefore, the first requirement of an effective assessment and resettlement model is that it clearly differentiates between strategic planning tasks and service component/project planning, and recognises the need for two distinct stages of information gathering and 'assessment'. In some current planning there seems to be a sense of confusion and compromise between these two levels of information, resulting in assessment exercises which fall between two stools – too complex and time consuming to guide broad strategic decisions but too superficial for individual care planning and imaginative service design.

In our experience, detailed profiles of individual long term patients are not routinely available through professional records or immediate care staff. Our work on assessment has shown, for example, the importance of carefully exploring patients' social networks (the set of meaningful relationships patients have with other people inside and outside the hospital) to ensure that relocation decisions maintain existing supportive contacts as far as possible. Social networks often do not conform to professional expectations and groupings. Only one or two contacts may be important out of twenty or more people living on a ward. There may be stronger links with people living outside the hospital. Identifying these networks is in itself a task requiring considerable time – perhaps a minimum of three to four hours for each patient.

The importance of this type of individual-centred information and the need to commit skilled staff to collect it and to act on it has major implications.

In most situations it will only be realistic to focus the limited assessment and rehabilitation resources available on relatively small numbers of patients at any one time. *An effective resettlement model therefore has to have the capacity to identify patients who will have priority in the relocation process before detailed individual assessment and care planning are carried out.*

An appropriate model for relocation has also to reflect four other considerations. Firstly, there is the importance of maintaining the viability of the large hospital as an effective organisation during the period of contraction. A transition strategy which 'creams off' the majority of younger patients with lesser disabilities in the first three years or transfers professionally prestigious services – acute admission, academic research and teaching, psychotherapy – ahead of services for the more disabled or elderly patients seems likely to risk creating an unmanageable and unstaffable institution in a short time.

Secondly, there is the need to maximise revenue savings at the hospital through relocation in order to transfer resources to the new local services. Some double running costs are unavoidable until the transition process is completed but closure and transfer of resources achieved at ward level may bring greater savings than removing individual 'beds' from a large number of wards.

Thirdly, it seems likely that this large scale operation will generate a great many new ideas about community-based services, particularly for people with long term and severe disabilities, where our current experience is limited. Service models planned in the early years of the transition are likely to be superseded fairly quickly in the light of the experience of running them in practice. It may therefore be appropriate to aim for a relocation model which from the outset generates successive 'waves' of patient and staff transfers, each with the capacity for experimentation, appraisal and change.

Finally it may also be wise to predict an element of unpredictability. However thorough the preparation, some delays in the completion of scheduled projects are likely and unexpected new service development opportunities can emerge that could not be anticipated in advance. Viable resettlement processes require robustness to cope with delays or mistakes, and flexibility to capitalise on unexpected opportunities.

Designing relocation: basic principles

The complexity of the task and the need for pragmatism in the face of limited resources and time make it all the more important that those involved in planning the relocation process have a very clear set of standards by which to judge their performance.

We suggest that similar principles should guide the design of arrangements for both relocating patients and redeploying staff. These are set out in Table 1. The principles can be understood as aspirations, departures from which need to be rigorously justified. In some areas there will be trade-offs between one aspiration and another, requiring careful examination of how patients' best interests can be served within the constraints enforced by limited resources.

A model for relocation and rehabilitation

These considerations have led us to formulate a step-by-step model for managing the relocation of patients and staff. This model is an attempt to reconcile the practical realities and challenges of service development activity with the key principles. It is not intended as a blue-print for service planning. It deals only with some of the assessment and patient transfer processes. Many of the other prerequisites for a successful transition strategy – appropriate personnel and financial policies, staff training arrangements, local and strategic leadership and so on – are not referred to. A description of the model follows and is summarised later.

Step 1: Establishing a communication and information system

A precondition for any assessment and data collection activity is the establishment of an effective communication system across the hospital and the user districts. Around the country, this has included newsletters, leaflets, and videos; presentations and seminars held in the hospital and the user districts; information rooms and travelling displays giving up-to-the-minute details on policy and the practical arrangements for transition, proposals for local services and so on.

Table 1 Basic principles in the design of relocation arrangements

FOR PATIENTS	FOR STAFF
1 Patients should move to a better service:	1 Staff should move to a better service:
2 ... in a locality where they have meaningful links.	2 ... in a district for which they have expressed a preference.
3 ... in ways which sustain existing social relationships wherever possible.	3 ... in ways which sustain existing relationships wherever possible.
4 New services should be designed around the strengths and needs of individuals and small groups.	4 Relevant staff should be involved in the design of new services around the strengths and needs of patients they know.
5 Patients should be involved in decisions about 1, 2, 3 and 4.	5 Staff should be involved in decisions about 1, 2, 3 and 4.
6 Patients should be offered skilled support in contributing to these decisions.	6 Staff should be offered skilled support in making decisions about their own future job.
7 Careful efforts should be made to prepare patients for moving into new situations.	7 High quality development opportunities should be available to prepare staff for relocation and equip them for the practice of new roles and skills.
8 This preparation should seek to minimise 'interim' disruption to patients' lives not directly relevant to relocation.	8 Any staff movement within the hospital should be carefully planned with the preceding principles in mind.

Alongside these ad hoc channels, the usual management and staff meetings have been used with varying degrees of success. Whichever way the process is organised, it should include health and local authority staff at all levels, inside and outside the hospital, and the patients. The process from the outset will have a general role in dispelling myth and rumour about relocation. Once information is available, the system should be able to get it to the people who need it promptly and without ambiguity.

Step 2: Who is planning for what?

Hospital managers and staff in the districts using the hospital need fairly quick answers to a number of questions.

- How many districts will receive patients and resources?
- What are the geographical areas for which each authority takes responsibility?
- What are the rules for allocating 'non catchment' patients from outside the districts?
- How are the people from the districts currently located across the hospital wards?

Hospital managers may have to do some work using existing record systems in order to

create a map of all the hospital wards showing distribution of patients from different districts;

provide 'user' districts with information about the numbers of people who are allocated to them, broken down in fairly rough and ready terms: for example

- by age, that is over/under 65
- by assessment of dependency, that is in three levels
- by sex
- other categories relevant locally

At this stage most districts do not need much detail and it is too early to make firm decisions about named patients. This is essentially a paper exercise for which some collation of information from records at ward level may be helpful, although it need not involve full assessments of large numbers of people living in the hospital. It is not a sectorisation process. *Patients are not moved from the wards they are living in on the basis of this data.*

Step 3: Investigating physical retrenchment options for the hospital

This is mainly a technical exercise looking at options for the phased withdrawal from the site. It should take into account such things as the capabilities of the heating and catering systems, the possibilities of selling land, the physical conditions of different ward blocks, and so on.

Step 4: Guestimates about the first wave of local provision

In an ideal world, by now district planning groups and project subgroups would have organised themselves, used the data from step 2, consulted the hospital staff and patients, clarified their own vision of a local service and set out some priority projects based firmly on a detailed understanding of the needs and wishes of a number of hospital patients. Reality is likely to be rather different. One or two proposals may have been imaginatively tailored to the needs of individual patients and small groups, but others will be the byproduct of political and professional compromise in district planning groups, off the peg models left over from a previous plan or ideas borrowed from a neighbouring authority. Some districts will be more efficient than others in making proposals so there is likely to be imbalance in the early stages. As with most planning processes, it is useful to understand that what appears in the first or second district plan may be very different from the final services which come into operation. Typically these early proposals change a great deal in response to consultation, input from staff, pressure groups and so on. They are best thought of and presented as a 'first guess' which must be modified and improved in the light of more detailed knowledge of the patients and their wishes.

Despite their limitations, the proposals that emerge at this stage represent an agenda for discussion between district planners and professionals and the patients and staff in the hospital. They can be a focus for meetings, educational events and visits. It is important that there is a recognised channel for collecting information about individual schemes in order to keep them up to date. This is to be clear about which schemes are due to open in the next 12–18 months, how many people they are intended to serve – age, sex, dependency characteristics – and which user district is involved. As far as anyone can judge, it is to these schemes that the first wave of hospital patients will move and the timescale is such that selecting and preparing patients should be carried out now. A group of senior staff from the hospital and the user districts with a mandate to act as a clearing house and information resource for all of the schemes can keep track of developments and help to resolve problems in the practical arrangements for relocation.

Step 5: Consultation with hospital staff on relocation preferences

Step 4 will suggest the characters of the user districts and indicate the direction their services are taking. By step 5, hospital staff should have had the support of appropriate personnel and training policies. Some may decide to transfer with their patients to a district. Managers will be concerned about developing challenging projects in the hospital to ensure that a fair proportion of well qualified, talented staff stay rather than move out with patients.

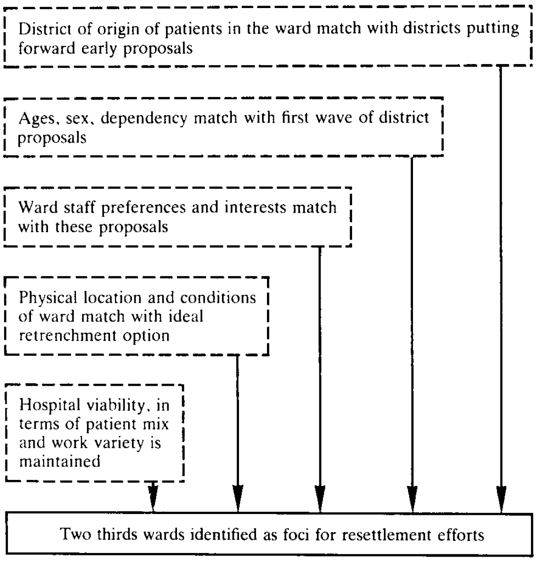
Step 6: Identifying priority relocation wards

Basically steps 1–5 have been preparation and information gathering tasks. It is from this point that detailed assessment and resettlement activity begins. It is at this point too that the major difference between this relocation model and the traditional rehabilitation system occurs. The task now is for managers, in consultation with hospital staff and district colleagues, to identify a small number of wards (two, three or four) which will be the first to close and transfer in the next 12–18 months. By the end of that time all (or almost all) of the patients, and all the staff and resources associated with the wards, will have been transferred to the user districts. 'Priority wards' are intended to

- focus relocation work on a manageable number of patients (60–80) at any one time so that individual assessment and consultation can take place.
- create a focus for resettlement activity in a small part of the hospital and minimise disruption.

Selecting priority wards will involve the consideration of a number of factors (see Figure 1) and it is aimed at achieving the best possible match between the first wave of user district proposals and the general characteristics – age, sex, district of origin, rough dependency levels – of the people living on the wards.

Figure 1 Criteria for selecting priority wards



Two points are worth stressing:

(i) It will be fairly easy to correct any mismatch in 'district of origin' at this early stage by 'paper' adjustment of 'out of catchment' allocations and by agreed 'swaps' between districts of the named patients for whom they will take responsibility.

(ii) The match between the first wave of proposals and the wards is not intended to be exact. It is a first guess which may suit a large number of patients but which will also point to patients living on the wards for whom there is no current service. It is one of the principles of the 'priority wards' model that hospital, district, regional and local authority agencies involved *agree* to give high priority to the task of creating suitable alternatives for these patients. This will give hospital-based staff incentives to initiate project planning around the needs of very small groups of patients.

Step 7: Exploration of social networks

Before making detailed individual assessment and preparation on the priority wards, it will be necessary to understand the pattern of friendship and social support among the people living there. The ward staff will need the help of specialists in resettlement/rehabilitation to do this. The size of these important networks is likely to be small, seldom more than four people. Some patients will be close to people living on other wards and decisions will have to be made about whether the 'outsiders' are to form part of the priority group. This is a period when staff and patients on the priority wards should take time to discuss their general feelings about the transfer and their hopes and fears for the future. The task on the wards will be to match as far as possible individuals and their friends to the alternative provision being offered by the user districts.

Step 8: Individual assessment and preparation for resettlement

At this stage it becomes feasible to begin detailed assessments and planning for individuals and small groups of patients. It is now that the introduction of a key worker system, use of techniques such as 'getting to know you', nursing process and more general skills training becomes appropriate.

Staff and patients on the wards should be in a position to discuss, evaluate and adapt the proposed designs and operational policies of the first wave of user district services. There will be opportunities for visits to the proposed provision, and close working between the local staff and those currently living and working in the hospital.

The recruitment of independent advocates to act for individual patients on the priority wards is a way to make sure that the interests and views of patients are represented with those of hospital staff and professionals in the user district. These advocates may have a particularly important role in monitoring the match between the new professional services being offered and the wishes and needs of individual patients.

If user district planning groups have done their job well, with adequate early consultation and in line with the principles set out above, the proposed services will reasonably match the needs and wishes of individuals and small networks of patients. There will be flexibility for the necessary changes and tailoring to improve the match. The lead time of 12–18 months will be long enough for the preparation and redesign tasks but not so long that it becomes a meaningless abstract activity for hospital staff and patients.

There will also be a large or small amount of 'mismatch' between the first wave of proposed services and the identified needs of the people living in the hospital. Perhaps the proposed provision is too institutional in character and scale or the proposed level and variety of staff input is wrong, and so on. When it is felt that a proposed local service requires substantial rethinking, or the overall amount of provision on offer is not enough to meet the needs of all the patients living on the priority wards, project design groups of ward and local staff, patients and advocates and members of the resettlement and rehabilitation team can be given the task of developing new proposals for small groups of patients. A 12–18 month lead time makes this feasible *provided* these groups receive the appropriate priority and backing from senior district, local authority, hospital and regional officers.

Step 9: Patients and staff move to new local services

If there has been good overall coordination across the local project development groups and the priority wards, it should be possible to aim for synchronised dispersals from any ward within a short period of time. Now individuals and small subgroups of patients leave the ward and move to the new services in user districts. Some staff who have been working with patients on the priority wards will have chosen to apply for jobs in the user district services. They will move with their subgroups of patients. For other staff this will be the time to transfer to other long term wards in the hospital, or to other jobs.

Resettlement staff who have been working with the patients and ward staff on the priority wards will continue to work on a peripatetic basis with the patients in the new district provision. Although a certain amount of assessment and preparation work will have been carried out before the transfer, the bulk of the intensive rehabilitation and training effort will take place *after* the transfer. This will be the time when both patients and staff will require the most intensive additional support.

Practical day to day experience will indicate further adjustments to the operation and staffing of local projects and changes in the care plans for individual patients. In the new setting, some patients will prove to be less dependent than had been anticipated while some will require more help or different forms of help than was predicted. Patient advocates will be involved during and after the relocation and staff remaining in the hospital will have an important role monitoring the operation of the new services and ensuring that the quality of life of patients is better than it was before the move. As patients and staff in the first wave settle down, resettlement/rehabilitation staff can be withdrawn from the new services for redeployment on the next priority wards.

Step 10: The cycle repeats

Informed by a systematic review of the first wave of reprovision and the successes and failures of individual projects, steps 2–9 will be carried out again. The review may encourage earlier and fuller coordination between user district planning groups, the front line staff and the patients on the hospital wards. Short cuts, alternatives and better coordination systems may be found. If the results are encouraging the process will continue until the final wave of reprovision completes the task of creating imaginative user district services and leaves the hospital empty. This model is summarised on pages 8 and 9.

Organisational implications

There are two important organisational implications arising from this approach which require explicit attention.

1 Sectorisation

Our development of this model came from working with staff at an 'unsectorised' hospital serving a large number of user districts. This undoubtedly adds to the complexities.

On balance we do not think that the upheaval in major internal reorganisation can be justified at an unsectorised hospital if contraction and closure are expected over the next decade. Our model allows a form of 'paper sectorisation' at step 2 which gives each user district an accurate picture of the numbers, important general characteristics and current location in the hospital of people who will be their responsibility. The 'priority wards' model does not require that all patients come from one district or that they all move out to the same district. The evidence we have suggests that widespread 'rationalisation' of existing hospitals using 'district of origin' or 'dependency' information obtained from records and general surveys is likely to cut across and damage important relationships among patients and between patients and staff. The amount of work required to carry out these internal transfers, and their disruptive effects on staff and patients, seem on the whole likely to distract attention from the task of moving patients and staff out of hospital to local district alternatives.

2 Rehabilitation services

The model presents a set of tasks for staff with expertise in assessment, resettlement and rehabilitation which is different from the tasks carried out in a large static hospital. Here the task is to work on a small number of existing wards. On the whole, the work will not be in rehabilitation units, half way houses or similar specialist sites. Indeed most of the rehabilitation effort will be outside the hospital in the new services. Specialists in resettlement/rehabilitation will operate in teams working on a peripatetic basis inside and outside the hospital. They will allocate large numbers of staff to specific wards or projects at times of intensive support and withdraw them when need lessens. This pattern of work will be familiar to consultants with an interest in rehabilitation, and to occupational therapists, nurses, psychologists and social workers. What would be different in our model is the scale of the operation and the dramatic increase in the amount of time spent away from the hospital. The other major difference will be their working with patients who are, on the whole, older and have higher levels of psychiatric disability than people commonly found living in 'rehabilitation wards' at most hospitals.

The resettlement/rehabilitation teams' major professional role in the transition process will require an appropriate level of staffing and resources. As the process develops, individual team members may decide to remain permanently with a user district where they have been providing short term support. Hospital based staff may be interested in taking up a peripatetic role with the team rather than transferring to a user district service or another ward in the hospital. There is scope for local variation in the ways the rehabilitation team works and for changes in different phases of its operation. There are four key differences between a rehabilitation service in the 'priority ward' model and the traditional hospital service.

(i) Traditionally, staff stay where they are while patients move through the system to live and work in different settings with different staff. In the 'priority ward' model both patients and ward staff move out (in some cases, remaining together).

(ii) Traditionally, rehabilitation is focused on specialist units – halfway houses, intensive training wards and so on – with the major input *before* the patient moves out. 'Priority ward' rehabilitation takes place in the ward and day time settings, and in the new district settings, with most input *after* patients move out.

(iii) Traditionally, patients are selected to move out on the basis of assessments of 'low dependency', successful recovery, cure, and so on. *All* patients move out of 'priority wards' and they could have been selected for their high levels of 'dependency' or 'illness'. The task is not to decide who is ready to be discharged, but how services are to be set up to allow these people to live locally with continuing support.

(iv) Traditionally, rehabilitation has drawn individuals out of their existing social networks on wards to recreate networks within the rehabilitation system. The emphasis in the priority ward is on maintaining existing networks before, during and after transition, even if this means cutting across 'district of origin' or 'dependency' categories.

A model for relocation and rehabilitation: summary

Steps	*Some implications for managers*	*Some implications for staff*
1 Establishing an information/ communication system in hospital and across districts	● Making available time, staff and space to do this	● Access to reliable up-to-date information on plans and progress
2 '*Paper* allocation' of present in-patients to districts including both 'district of origin' and 'non catchment' patients	● Agreeing rules for allocation	● Informed of purpose and outcome
– This would be an administrative list for planning and monitoring purposes, *not* a decision about named individuals		● Informed/consulted on future admissions
– A basis for providing user districts with rough information on numbers/ages/sex/ 'dependency' levels	● Arranging a simple survey or census if needed, and making information available	
3 Investigating physical retrenchment options for the hospital	● Mainly technical exercise	
4 Taking stock of provisional district proposals for local services – making a guesstimate of *first wave* of provision to open	● Identify named liaison staff in districts ● Arrangements for district visits, handouts, presentations	● Access to a district staff contact and information on proposals
5 Consultation with staff about preferences on relocation. Not a change in job or contract, a chance to express and take note of interests and constraints	● Arranged in consultation with unions and managers ● Time and staff needed to do this	● Access to advice representation and support by unions and managers

Steps 1–5 are information gathering and preparation activities. Only from this point on does any change take place in the day-to-day lives of (a minority of) staff and patients.

6 Identification of 2/3 wards to be a priority for transfer in the next 12/18 months	Managers have to juggle 4 or 5 factors in selecting these priority wards (see Figure 1) ● Involvement of liaison staff from the relevant districts ● Opportunities to recruit new staff if needed	● All staff informed ● Detailed discussion with staff on the 2/3 wards involved ● Opportunities to swap wards if requested ● Time and space for staff and patients on 2/3 wards to talk

ASSESSMENT, REHABILITATION, RESETTLEMENT

Steps	*Some implications for managers*	*Some implications for staff*
7 Exploration of social networks and friendships on the priority wards and links to localities	● Allocation of additional specialist resettlement input to the wards	● Ward staff actively involved
	● Opportunities for patients to swap to match their network of friends	
	● Adjust step 2 paper allocation	
8 Individual and group preparation to move	● Input by resettlement and district staff on wards	● More detailed work getting to know individual patients
– More detailed individual assessments and planning	● Recruitment of independent advocates for patients	
	● Assessment of 'match' of patients needs to districts proposals, and where there is 'mismatch' – a) districts have access to other wards	● Staff discuss, evaluate, adapt proposed operational policies, visit districts
	b) high priority given at all levels to produce alternatives	● Active involvement by ward staff
9 Patients and staff move to new services	● Coordinated to achieve ward 'closure'	● Priority ward staff move with patients, transfer to other wards or into resettlement team
	● Resettlement staff temporarily move with staff and patients to districts	● Long term monitoring of outcome by remaining hospital staff
10 Cycle repeats	● Review of next wave of district proposals in light of experience	● Early active participation by hospital staff in planning

MANAGING [illegible]

MANAGING PSYCHIATRIC SERVICES IN TRANSITION
WORKING PAPERS

6

Collaboration for change

Partnership between service users, planners and managers of mental health services

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This paper is the result of a group meeting regularly to discuss issues about collaboration in mental health services. Its members are largely concerned with facilitating collaboration between health and local authorities, voluntary organisations and user groups. The difficulties associated with joint planning for community care motivated the formation of the group. This has remained the focus of our work together, but our understanding of collaboration has come to encompass many ideas from outside the mental health field.

The paper has been written to share some of our work and to get feedback from others interested in these issues. The form of a discussion document was chosen advisedly as we want the paper to stimulate further discussion and debate. There are no definitive answers in these pages but there are suggestions, ideas and, we hope, talking points.

Members of the group are:

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Introduction

This paper looks at collaboration between service providers and service users in mental health services, although a lot of what follows will be of interest to all groups involved in collaborative ventures. There are two components in the process of collaboration: first, users themselves need to work together to find a collective voice; second, staff need to be enabled to hear and act upon what users are saying. This document is not about 'how to do' self advocacy, but about how staff can look to their own attitudes and working practices to ensure good and effective collaboration with service users.

There is often confusion around the notions of collaboration, participation and advocacy and it might be useful at this stage to define our terms clearly.

Self-advocacy is the assertion of wishes and rights by an individual, the expression of needs and concerns. This country has seen a recent growth in the self advocacy movement. User groups in both mental illness services (to be dealt with later) and mental handicap services (for example, People First[1]) became established as users started to speak out collectively for themselves.

Citizen advocacy is when people, sometimes less able to speak for themselves, have a representative to act on their behalf. Citizen advocacy is more established in mental handicap services; for example, projects like the National Citizen Advocacy Project.[2] Legal advocacy gives advice on legal and welfare matters and provides representation to the Mental Health Review Tribunal. The Mapperley Advice Project[3] and the Advice and Legal Representation Project at Springfield Hospital[4] are examples of legal advocacy. Advocacy of any kind should not be confused with participation and collaboration, although the development of advocacy will almost certainly facilitate such activities.

We have used participation as a term applying to the overall field of user involvement in mental health services. Its literal meanings of 'sharing in common' or 'partnership' have many implications in practice. For instance, participation might take place at the user/practitioner level, that is, at the point of service delivery. Participation at this level will probably be therapeutic in nature. Participation could also occur in the management of services and at the level of planning and development of services.

The term collaboration has an equally wide remit in its translation as 'cooperation' or 'working in conjunction with others'. However, this document defines it as collaboration between statutory agencies, voluntary organisations and user groups in the joint planning of mental health services. We have chosen this focus because it is currently receiving much attention in the mental health service. We have not, though, focused only on planning; a lot of what follows applies equally to user involvement in managing and evaluating services.

This paper, therefore, reflects on why and in what way mental health services should actively seek to involve users so as to offer a comprehensive and appropriate service.

Participation – past and present

The move towards involving users in the planning and delivery of services reflects an established trend in the social policy field towards greater user participation. Throughout the seventies, events such as the setting up of CHCs in the 1974 NHS reorganisation, the 1971 Seebohm report on Social Services Departments, the Taylor committee on school governing boards, and the DOE report on housing tenancy in the same year, all proposed greater user involvement. In the health service, the Griffiths report in 1982 firmly placed consumerism centre-stage, as did the 1986 Cumberlege report on community nursing. Participation in mental health services was advocated in the DHSS Draft Circular[5] and one of the most innovative suggestions to emerge from this particular development has been the recognition that service users have an essential contribution to make to service planning. The circular states clearly that 'planning should be directed towards meeting the needs of individual patients and clients... Service providers, clients, their families and community representatives including those of ethnic minorities are to have the opportunity to make a contribution to planning, ensuring the plans are seen by consumers...'

The Disabled Persons Act (1986), sponsored by Tom Clarke, supported these developments by formalising advocacy for people with disabilities.

However, the welfare state, with no history of either participation or consumerism until recently, has not sought to actively involve users in decision-making processes. The difficulties of introducing the practice of participation in 'expert-led' services have often led to user involvement being tokenistic or ignored altogether. There are examples of users actively participating in the decision-making processes (for example, Chesterfield Community Mental Health Centre) but the dissemination and adoption of these ideas has been minimal. As Richardson[6] notes, the traditional pattern of planning services has been the identification by experts of the most effective policies for meeting what they consider to be people's needs. The assumption that users have little interest in this process, leaving it to experts to ensure they are well served, is hard to destroy.

Other historical factors militating against user involvement have been defined by Webb and Hobdell[7] as the 'authority of position' and the 'authority of knowledge'. The authority of position are those professional and bureaucratic hierarchies that have historically shaped welfare services, and the health service in particular. Authority of knowledge is the organisational principle enshrined in the professions; that is, a body of knowledge held by particular professions which require specified training to master and possess it. Nobody can be seen to be making a legitimate contribution to the service system without it. Position in the hierarchy and possession of knowledge are closely linked and are given authority and legitimacy by the ideology of an 'expert-led' service. Indeed, for the health service to operate in the way it was originally meant to do, position and knowledge would have to go hand-in-hand, otherwise how could planners and managers justify 'knowing best'?

The consequence for people using the health service was that any contribution they might make was neither authorised nor legitimised by the system. Participation, where it existed, was little more than lip service to an idea; the underlying ideology and decision-making structures were never really tackled. However, the system contained the seeds of its own destruction. Dissatisfaction with the direction and form of the health service grew and was identified as a political issue. The limits of the old 'bureaucratic paternalism' forced alternative strategies of reform into the limelight, characterised by privatisation or public provision solutions.[8]

The political spectrum

One of the major problems in establishing participative structures in any organisation is the different meanings of participation held by people of different political and philosophical opinions. The nature of demands for reform in the health service has ranged between the right/left extremes of the political spectrum. The major ideological stances of this spectrum are as follows.

A non-market critique is based on a view of the welfare state as an oppressive and dehumanising system. Services needed by people are offered in a way that disempowers the user and thus maintains the status quo. Participation in this sense would involve a large scale transfer of resources and their control to the local community.

The social democratic lobby based on a commitment to 'welfare pluralism', believes that the traditional welfare service has become financially and bureaucratically untenable. This approach looks to a model of services focusing on decentralisation and increasing voluntarism. Participation becomes a central plank as people influence their own local services through the development of locality planning and the increase in voluntary organisations.[9]

At a further point along the spectrum, an analysis of the welfare state from a market-based perspective sees the all-embracing nature of the state as being in direct conflict with individual choice and marketplace competition. Efficiency is stimulated by the need for commercial viability. Participation is seen to mean freedom to choose the type of service when you want and how you want.

Thus participation has become a more prominent issue, at least in political and philosophical circles, largely in response to growing disenchantment with the welfare state as it is. However, as Beresford noted in 1981 '... for all the interest in public participation, hardly any seems to exist'.[10] Sadly, seven years later this is still true for mental health services and, one suspects, for other areas of the welfare state as well.

Participation in practice

Clearly one of the major reasons for the virtual non-appearance of participation in the social policy field is the absence of a single ideological message; and the fact that, even within a particular school of thought, participation remains an elusive concept. As Maxwell and Weaver[11] have noted, the variables determining the degree of public participation are:

the nature of the service;
the nature of the client group;
the nature of the provider organisations.

The interaction of these relevant factors at local and national level, and all stops between, is difficult enough. With political interplay added, the definition of participation becomes almost an individual affair, ranging from public consultation and consumer protection to planning and management of service delivery by service users.

The current situation in the user movement reflects the diversity of political approaches and the lack of an overall message.

- Some groups are advocating user-run services and feel their experience of the psychiatric system is one of disempowerment and restriction of rights. A response to this system means tackling the imbalance of power between service users and service providers by increasing user control over resources.

- Other user groups are asking to be involved in monitoring services and training workers, and to be represented in planning; because they seek to influence services at a local level, they do not want to be directly involved in managing services. Nottingham Patients Council Support Group[12], a group of users and ex-users, has been involved locally and nationally in training events for staff. The council works to instigate user-only meetings in wards, day centres and community mental health centres and will support such groups in taking up issues with staff and management. The council has also established working relationships with the health authority and influences the planning and management of the mental health services.
- Some user groups are asking for changes not directly related to deficiencies in the health system, such as higher benefits or better employment opportunities.
- Yet others are asking only for better services from the psychiatric system, such as improved outpatient facilities; or see their role as supporting other users in an advocacy framework. The Resettlement Support Group[13], based in North Manchester, is a user group which offers support to people who are being resettled in the community. The group initially met at the request of Harperhey Resettlement Team who wished to discuss their plans with people who had first-hand experience of living in hospital, moving out, and living outside. The group continued to meet and opened up membership to anyone who uses psychiatric services. User groups such as Womankind[14] and the Afro-Caribbean Mental Health Association[15] seek to provide a service, including an advocacy service, to specific groups of users; in this instance, women and Afro-Caribbean people.

Even within the relatively narrow field of joint planning between health and social services there are different definitions of collaboration. As we shall see below, these are based largely on what the planning team perceives to be its remit and objectives. Diversity is not a bad thing and, indeed, should be supported and encouraged. However, when engaging in collaboration it would seem useful to have a sense of the nature of potential political and philosophical differences, and to be clear about what the other parties mean by collaboration. This requires an understanding of the collaborative venture within a wider conceptual framework. We shall be suggesting such a framework below.

Is consumerism participation?

The major initiative from the State on the issue of participation has been the notion of consumerism. Promoted by Griffiths, the supermarket metaphor now has the consumers taking their shopping trolleys around the health service. On the surface this analogy would seem appropriate for mental health services, offering the consumers choice and control in the services they receive. However, in a rush of enthusiasm to embrace consumerism, the degree of participation being offered may be overlooked.

If we look further at the supermarket analogy there are a number of significant discrepancies that militate against its use for mental health services. There are practical problems; people know where to find the local supermarket, know what it will look like inside and what to expect when shopping there. In contrast, finding appropriate services in a district can be a difficult task for the uninitiated. People have to rely on others, usually their GP, to guide them. Already there is a powerful intervening force between the consumer and his or her goods.

In a supermarket, shop assistants are helpers only; they will not interpret behaviour, restrict access to certain goods or compulsorily detain people. To assume that professionals are merely helpers and distributors of services denies the reality of the relationship between service providers and users, which is based on the interpretation of an individual's experiences within a professional framework, be it medical, social or psychological. Equally, service development is not based on a model of consumer-driven market forces but, as we have seen above, on what professionals wish to provide according to their understanding of the problem. A solely market-led development of services would create a deep philosophical split in the current structure of the NHS. As Maxwell and Weaver[16] have succinctly stated:

> The whole justification for its (NHS) existence lies in the rejection of the market principle as inappropriate for the organisation of health care. It is this which, in a sense, gives moral legitimacy to the paternalism of the providers.

This would, indeed, seem to be a dilemma. The drive for greater participation largely arose from dissatisfaction with the paternalism of the existing NHS structure, yet consumerism would lead to our questioning whether the NHS should exist at all. A radical extension of consumerism would mean no role for an expert body of knowledge in service planning, as distinct from consumer demands. These widespread implications are far from the spirit of participation embodied in the recent move towards user involvement in mental health services.

The dilemma though, is false and further highlights the necessity for genuine participation. Participation, in fact, is not a necessary condition of consumerism. Winkler[17] in her excellent article on consumerism in health care, states that:

> The supermarket vision of customer relations extends to reducing the waits at the check-out counter and exchanging faulty goods with the minimum of questions asked. It does not extend, even at Marks and Spencers, to inviting the customers on to the board, nor to consulting them about investment or even about what should be on the shelves, let alone in their products. The supermarket concept certainly does not mean that retailers help customers sue manufacturers of products that have caused harm.

Consumerism, as it is currently being promoted, would not bring about major changes – being more about 'the appearance, not substance, of change'.[18] Consumerism *does* imply choice in deciding whether to 'buy' or not, but true participation as we originally defined it, as partnership and sharing in common, does not necessarily follow.

Where does this leave the notion of collaborating with people who use mental health services? Despite a common base for promoting participation (that is, a wish for a more responsive service) today's initiatives are clashing ideologically and politically and making few inroads into real policy decisions and service planning. Perhaps we need to return to the basic starting point and look behind the assumption that users *should*, indeed, be involved.

Collaboration – why do it?

One of the most powerful arguments for user involvement is that people with a mental illness have the same rights and, as far as possible, the same responsibilities as other people, including the right to self-determination and to influence and shape the services they receive. This argument is relevant for all health services, and it is particularly so for priority services which may have a significant impact on a person's life. Mental health services intervene at social and psychological levels, as well as at a medical level, which further supports the argument for individual choice and control over these interventions. It is widely held that infringement of an individuals' rights through non-consultation and limitation of responsibilities affects the rights and dignity of every ordinary citizen.

Ethical reasons, however, may not be the most persuasive in a health service trying to cope with increasing cutbacks and growing financial constraints. A different reason – and a very powerfull one – is the search for an effective and efficient service. How can managers be sure that services are relevant to people's needs unless they involve users in planning those services? How can mental health workers assess the quality of their work unless they seek the views of those affected by their work?

The mental health field is not one where experts know best. There is no single body of knowledge that informs the service and many different theoretical and practical perspectives are employed to help an individual. Feedback from the point of service delivery is essential to ensure that the user is benefiting from what is being offered.

There are also what can be loosely termed 'therapeutic' reasons for involving people in planning and determining the services they receive. The experience of mental illness is largely characterised as loss of control – over one's mental state, one's environment, and one's freedom if detained under the Mental Health Act. If contact with mental health workers further limits or prevents people gaining control over their lives, then the legitimacy of the service is challenged.[19] In seeking to help people re-establish control over their lives, their relationships with workers will be vital in promoting a sense of worth and competence.

The growing reality of community care will further highlight the need to involve users in facing the challenge of the transition to community-based services. To avert what may be a crisis in care we must recognise and use this important resource in order to offer a comprehensive and appropriate service.

Structure of collaboration

We have looked at why the demand for participation in the health service developed and, more specifically, why mental health services need to involve their users. There are many different types of participation however, and confusion can be avoided if providers and users are clear about the activity in which they are engaged.

Windle and Cibulka[20] have defined three dimensions that provide a framework for understanding different forms and degrees of participation. This framework can be used to ask questions about the nature of participative activities.

1 Power dimension

This has three major levels:

(i) Citizen power:

- user control over services;
- delegated power;
- partnership between service providers and service users.

(ii) Tokenism:

- placation;
- consultation of users over plans and so on;
- informing users about plans.

(iii) Non-participation:

- therapy;
- manipulation through professional power.

This dimension provides an interesting way of analysing participative ventures. If claims are being made for the exercise of power by service users, then the extent to which power will be truly shared can be assessed by using these categories. Tokenism and non-participation are alright so long as both sides are clear as to the type of interaction that is occurring and the implications for the balance of power.

2 Participant dimension

This has four categories:

a) Communities (including voluntary organisations)
b) Lay public
c) Service users
d) Professionals/workers

Looking at participants, this refers to the major groups of stakeholders in the service. These categories will, of course, overlap and their internal composition will change. Much discussion about participation is concerned with how representative people are of their group. However, it must be said that this discussion is usually focused on user groups; professionals are rarely asked how representative they are. Most user groups are clear about who they represent. A group from the community mental health centre would not represent the views of elderly people on long stay wards and would not expect to be involved in discussions about that particular service. National groups, such as British Network for Alternatives to Psychiatry,[21] have always stressed that members can state their personal experiences and not be representatives of 'users' as a single group.

There is a danger that, despite its challenge to professional elitism, participation itself may become an elitist activity and attract people seeking power for themselves and not for the group they represent. The choice of participants is an important task if true representation is sought in a group of participants and across relevant groups of stakeholders.

3 Functional dimension

Participation has different functions, or policy stages, which can be distinguished as follows:

a) Authorising – the legitimisation of a service development or programme through the support and mandate of the groups of stakeholders.
b) Enabling – the funding and resourcing of participative activities.
c) Planning – collaboration in planning services.
d) Managing – involvement in the management of services.
e) Service giving – the delivery of services.
f) Evaluating – research, service monitoring, peer review and so on.

Service users can be involved in any of these functions, although their involvement will be quite different in each. It is essential, therefore, that any participative activity is clear about the function it is undertaking.

This framework provides a way of clarifying who is involved in what activity, and the nature of the activity. Collaboration in joint planning should aim to be a partnership between service providers, service users and other relevant stakeholders in the planning of mental health services.

However, once the structure is established, how does collaboration then proceed? We will now look at the processes that a collaborative group may engage in to address the task of joint planning.

The process of collaboration

In developing a model of collaboration it was necessary to look outside the health service for ideas. Other sectors in society have a growing need to promote collaborative problem-solving between different organisations, for example businesses, communities and government.

Gray[22] has devised a model of collaboration that depends on the links between stakeholders and across agencies. It differs from the usual model of collaboration, which focuses on the organisational structure of a single agency.

Gray's model would seem to be an appropriate way to approach user involvement which, of necessity, involves different groups of stakeholders and different agencies. It is a process model based on the assumption that all stakeholders in the collaborative process are truly interdependent. The idea of interdependence is largely ignored out in the field (many professionals could well be reminded of their interdependence with service users, without whom they would not have a job!). Different agencies might also like to reflect on their interdependence with each other. Keeping in mind the over-riding goal of providing an effective service can help agencies to see themselves as part of an inter-locking system; this recognition is often the initiating factor for collaboration.

There are three major developmental phases in establishing collaboration. The following considers their relevance to the mental health service.

1 Getting going – identification of stakeholders

The first phase is concerned with the identification of the stakeholders and their respective positions. This could be difficult. Some stakeholders may question the priority of the issues being considered, some may be indifferent, some may not acknowledge the need to collaborate. Because stakeholders will change according to the issues being considered, their identification is a continuing process.

Before stakeholders can truly collaborate they have to believe in collaboration. 'Pay-offs' may have to be offered as incentives. Cultural norms supporting collaboration are a powerful incentive and management has a vital role in establishing such norms. Critical to this initial process, as mentioned above, is the recognition by each stakeholder that their actions are inextricably linked with the others. Legitimacy is also crucial. Stakeholders have to recognise the rights and capacities of others to participate.

In joint planning it is up to committed individuals to argue for the legitimacy and interdependence of stakeholders traditionally excluded from the planning process, such as users, their families, and voluntary organisations. Initiatives like the draft circular on joint planning begin to establish cultural norms which may bring pressure to bear on the intransigent, but it will undoubtedly be a challenging task. Legitimacy is clearly linked to power, and those with little perceived power may need to increase their power base before gaining legitimate status as a stakeholder.

User groups should look to building coalitions to support their position. Sympathetic stakeholders who are in a more powerful position should develop their role as advocate for less powerful groups. Who initiates collaboration has a critical impact on its success or failure. A relatively powerful stakeholder such as the health or local authority, is probably the best convener. However, in cases of extreme conflict a neutral third party, probably a voluntary organisation, may be more successful. This approach has given rise to reticulists, whose job it is to bring agencies and people together to collaborate. An example is the Lambeth Forum[23] which was set up by a development worker from an independent organisation, Good Practices in Mental Health. The forum included health and social services, voluntary and community groups, user groups, GPs, and other people with an involvement or interest in mental health. Its aims have been to monitor and evaluate service provision in Lambeth and to make comments and recommendations to planners and policy-makers. Coalition for Community Care operates similarly in Westminster, Kensington and Chelsea.

In summary, during this initial problem-solving phase, stakeholders are identified and legitimised, interdependence is recognised, preliminary expectations are established and the boundary of the collaborative venture is defined.

2 Mapping out the work – direction setting

One of the major tasks in the second phase is to establish the values that will guide the work of the collaborative group and set overall directions for it to pursue. This may take a considerable amount of time and effort, but is vital to the future work of the group.

Problem-solving is best facilitated by recourse to a superordinate goal which embodies the shared values of everyone. In joint planning this would be done by offering an effective comprehensive service for people in mental distress. Values, attitudes and expectations about the task need to be openly discussed and commonly agreed. For example, in planning ordinary housing for people discharged from psychiatric hospitals the group's shared values might be that people with a mental illness have equal human rights and, therefore, a right to ordinary, high quality housing. Establishing these shared values helps to create a path through the pitfalls and challenges that will occur in the planning process. The involvement of users is essential in order to place possibly abstract discussions in the context of daily life for people with a mental illness.

Another major challenge in setting directions is the difference in power between the stakeholders, some of whom will have greater control over critical resources than others; users will probably have no control at all. Some balancing of power is necessary for continued joint work, and to ensure that directions are not skewed by the interests of those with greater power. An effective argument to persuade stronger groups to disperse their control over resources is, again, the recognition of interdependence; also that sharing will stimulate creativity and that combined efforts are greater than the sum of individual (often conflicting) efforts.

The multi-agency Community Dementia Team which operates out of Guy's Hospital is an example of dispersed control. The consultant has given up her power of admission and discharge to hospital beds to the team, as did the local authority with their power over admission to Part III homes. Clearly defined management of people and resources by a key worker system ensured that referrals were not 'lost'. This has resulted in a more effective and efficient service to people with dementia and increased the ability of each agency to deal with the problem. It is an innovative and courageous step and is to be applauded in a field often fraught with conflict over territorial rights of access.

Once the group has defined common values and achieved a more equal dispersal of power, the positive benefits of collaboration will start to show. However, the collaborative activities need to be formally regulated to continue working – a third phase that involves structuring the group, formally and informally, so that it develops a life of its own.

3 Working into the future – structuring

The changes brought about by phases 1 and 2 need to be continued. The primary motive will be stakeholders continuing to perceive their interdependence. This is important if the group is to follow its set directions and achieve its goals.

A formal structure is usually established that assigns roles and responsibilities to ensure the implementation of action by people at senior level in the relevant agencies. There is a danger during the structuring phase that people who use the services will become marginalised and left without a role in the work of the group. Genuine collaboration means equal access for everyone. Are users, for instance, elected as secretaries/chairs to the group?

Making progress – problems and opportunities

We have looked briefly at the collaborative process with particular reference to service users collaborating with planners and managers, a process that is probably universal. It is complex and a simple description does not do justice to the tangled web of attitudes and expectations that everyone brings to a meeting or the personal and professional backgrounds that influence their interactions with other people.

Blocks to collaboration

The taken-for-granted world can make it especially hard for service providers to collaborate with users. The term 'user' is good on philosophy but short on realism; it rarely reflects the way mental health workers think or talk about users. More often they are thought of as patients, which has connotations of suffering and passivity. Social workers describe them as clients, a valued term in other instances (for solicitors, for example), which does not imply equality in this particular relationship.

Training and the use of a professional language affect service providers' views of their work. Training builds a web of myths, illusions and attitudes that can form a smokescreen which obscures what really happens between service providers and users. A worker affected by the meanings and assumptions embodied in the profession will interpret contact with users to fit a framework – either medical, social or psychological. How do we make sure that users are not misinterpreted; and conversely, how do we enable staff to understand what users say?

User groups in this country are seeking to understand their experience in social and political terms. This means that service providers must look to the unconscious, pervasive attitudes and values that society has towards people with disabilities which may influence them. The prejudice towards people with a mental illness that is often portrayed by the media, for example, is also more subtly and covertly reflected in those services that project a stigmatising and negative image of people who use them.[24] Effective collaboration with users will not be possible until mental health workers rigorously challenge and question their own assumptions and expectations of people with mental illness.

Disability awareness is about realising that we all have been exposed to stereotyped and negative views of disabilities and that we may handicap and restrict the people who use services in ways we do not immediately recognise.

Practical ways of facilitating collaboration

1 Resourcing user groups

For users to participate as representatives they need access to funds, rooms, a photocopier, secretarial support and so on. If collaboration is seen to be of value it must be adequately funded and resourced. Do user groups have the opportunity to use the boardroom for their meetings? Are they served refreshments? How do workers facilitate collaboration between users so they can, in turn, collaborate effectively within the system? A community work approach linking users with each other may be an important first step in aiding collaboration.

2 Sharing information

User groups will need information about the complexities of the NHS. The structure alone is difficult enough to understand, but users also need to know the politics that lie behind the way bureaucracy operates. Workers joining an established department have access to informal knowledge about allies and 'hot spots' in the district. This information is important, and user groups should be helped to 'work the system', but the emphasis should be less on educating users to collaborate with professionals and more on changing the structures and processes to make them accessible.

Brandon and Brandon,[25] in looking at the development of participation in mental health services, note the importance of users receiving information. They remark on the need to develop more effective systems for passing on information. This is an important point; collaboration requires an equal sharing of information between all groups and a recognition by staff of the two-way nature of this process. People who use services have a vast reservoir of knowledge about the service and about mental illness in general. Workers and users need to look at ways of using this information to increase knowledge and understanding of mental illness.

Groups such as Camden Mental Health Consortium[26] have generated their own information through research into the major needs of people discharged from hospital. The survey of a significant number of users in Camden was done to identify their needs in the following areas: housing, financial stability, work opportunities, day care, social and leisure activities, medical after-care and support in crisis. Recommendations for service development followed from the findings.

3 Changing working relationships

Staff can facilitate collaboration by altering the pattern of service delivery to work 'with' rather than 'on' people.[27] This change will help users to feel their worth and competence and assist the development of self-advocacy. Rose and Black,[28] looking at an advocacy/empowerment approach in mental health work, explore the changes in working relationships that would facilitate this approach. They challenge a psychiatric system that consistently 'submerges' people, keeping them passive, acquiescent and devalued.

For example, confidentiality underpins the status of workers, yet they continually breach it, usually without asking the individual, when liaising with other disciplines and agencies: users know this happens. Confidentiality, presented to them as being necessary for their care and the coordination of services, is preserved as part of the caring relationship and broken for the same reason.

This double-bind situation 'submerges' users; they become unable to challenge the breach of confidence if they wish to gain access to certain services. If workers are to change their relationships with users they must clearly state their rules of play. So far as confidentiality is concerned, it must be made clear when and what information will be given without the user's permission; when (written) permission will be sought; and what information will be strictly confidential to a particular worker or group of workers.

Communication with users should not only focus on the pathology itself (if at all), but on the effects of mental distress and practical ways of alleviating them. Workers may themselves have to become more aware of housing, social security, welfare benefits, and so on. We are not saying that staff should become experts in these areas, but that they must have a working knowledge of other welfare systems that affect their users.

Rose and Black state: 'It is our task to help make the thematic content of people's lives clear to them through the process of dialogue'. Workers use their skills in critical reflection and their knowledge of the themes of mental distress to understand a person's problems. This process will help individuals to look at common themes in their lives, including their own mental distress. It will also reflect the wider experience of alienation and powerlessness that many disadvantaged groups suffer. Staff must learn to work with what users are saying, not what they think they are saying.

4 Building partnerships

Workers must beware of overwhelming new user groups with demands to collaborate in the system. It may be that user groups will only ask for more information, or to be consulted on certain issues.

Staff may seek to subvert collaboration by handing over decision-making to people who are not prepared to take on this role. Users, like everyone else, need time and training to collaborate effectively. Staff must work with users to provide a structure in which to hand over decision-making at a pace set by service users, not themselves. Staff must also beware of passing on day-to-day decisions to users while keeping major decisions to themselves.[29]

'Skills for People'[30] is a project which provides training for people with disabilities to develop self-confidence and the necessary skills to be active members at meetings. The focus of the project enables people with disabilities to become co-planners, leaders of workshops and courses, committee members and so on. This support helps users to work on an equal basis with others; it increases the extent to which they can make decisions and take control of their own lives.

User groups, though, may view their best interests as being served through a campaigning role, as opposed to a participative role, and will not want to become involved in collaborative ventures. This wish to remain 'outside' the system must be respected and may be a necessary first step in developing confidence and assertion skills in individuals and groups. Users may also feel that a pressure group is the best way to promote their interests and that involvement in health service structures is not the best way to bring about change.

5 Collaborating with people who are severely disabled

Involving users who find it difficult to articulate their needs and their opinions because of institutionalisation or mental distress, is a challenge for service providers. However, it is particularly important to confront this challenge now that long-stay psychiatric hospitals are being closed and people are being resettled in the community. It is essential to seek the opinions of these people to ensure that the service being developed in the community does, in fact, meet their needs, and that they are enabled to make an informed choice about the options available to them.

Lambeth MIND[31] has been working with users on long-stay wards to discuss issues relevant to their move into the community. They have developed a simple game which aims to facilitate discussion on various aspects of housing. They have also assembled a set of slides and a large set of cards for use in hospital to provide information for users and engage them in thinking about their future.

It may be, however, that normal channels of communication are not sufficient for a small number of people to fully express their needs. In these instances, approaches such as 'Getting to Know You', pioneered by John O'Brien,[32] may be useful. This involves detailed observation of an individual over a long period and for 24 hours a day. The observation is an active process requiring constant attention; a nurse working on the ward cannot do 'Getting to Know You' as he or she is involved in other activities. It is preferable for an observer to have little or no knowledge of the individual before the process starts to avoid preconceptions. By building up an intimate picture of a person's life it is possible to infer their needs and the best options for their future.

Another challenge that may have to be faced is collaborating with people in a state of mental distress, or who behave very differently from other people in the room. Effective chairing can best deal with people who wander off the point or bring up 'red herrings', whether or not the reason is mental illness.

6 Training and support

Education and training will be required to change professional attitudes. Involving users in training programmes is an important first step in this process. We have already mentioned the work done by the Nottingham Patients Council Support Group. Other user groups directly involved in training staff include Glasgow Link[33] which has produced with ESCATA a video-based training package for mental health workers.

Collaboration with users will require workers, planners and managers to reshape their practices and learn the skills of dialogue and negotiation. This process can threaten people's professional identities and status, and question the pre-determined framework which has guided them throughout their working lives. It can be a liberating challenge for some, but a devastating experience for those with very fixed ideas about their work. Therefore, support for staff is a necessary part of greater user involvement.

7 Challenging the prevailing ideology

We have discussed the constraints imposed on user involvement by the 'authority of position' and the 'authority of knowledge'. The traditional, publicly recognised, linking of position and knowledge in the hospital hierarchy has meant that users have had no access to the psychiatric system except as patients. This needs to be challenged and replaced with 'authority of relevance',[34] meaning that legitimate access to decision-making processes of any kind would depend on the *relevance*of an individual's contribution to the issue being discussed, regardless of position or discipline. Clearly service users would have a large claim to be involved on these grounds.

Outcomes of collaboration

Given our limited knowledge about the practice of collaboration, little is known about effectiveness and outcomes. The complex nature of participation, politically and structurally, makes it difficult to evaluate. Also, its impact may be felt at different levels in different ways. The conceptual tools we are developing to look at the structure and process of collaboration are helping to identify problems of implementation. We hope they will soon enable us to assess outcomes as well.

Collaborating in the future

The ideas of participation and collaboration are receiving more attention and changes in practice are slowly emerging. The rapid growth of user groups is evidence enough that users are responding to the notion of self-advocacy and, in most instances, that service providers are equally willing to explore the possibilities of participation and collaboration.

The practical implications, however, still need to be addressed. What can users and practitioners do to improve levels of collaboration and participation? A response might mean devising guidelines for service providers to help them collaborate better. It might also mean helping users to better 'work the system' and set up improved arrangements for user involvement. Examples of good practice need to be identified and learnt from.

These are exciting times for mental health services. The changes in patterns of service delivery associated with hospital closures, and the emergence of new partnerships in planning and delivering care, have opened up new possibilities for a truly responsive and effective service. Practitioners and users should together grasp these possibilities and ensure that future mental health services are wanted by the people who will use them.

Acknowledgements

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References and notes

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14 Womankind. c/o University Settlement, 43 Ducie Road, Barton Hull, Bristol.
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MANAGING PSYCHIATRIC SERVICES IN TRANSITION
WORKING PAPERS

7

Annotated bibliography

ROSE ECHLIN, STUART ETHERINGTON,
SU KINGSLEY, HELEN SMITH and DAVID TOWELL

Introduction

In this paper we have set out to complement the other papers in this series by identifying published material which we have found particularly helpful while developing our understanding of how best to manage psychiatric services in transition. Su Kingsley and David Towell from the King's Fund College have been greatly assisted in this task by contributions from Helen Smith at the King's Fund Centre for Heath Services Development and Rose Echlin and Stuart Etherington at Good Practices In Mental Health (GPMH).

Like all the papers in this series this is meant to provide practical assistance to policy-makers, managers, professional staff, user and community representatives in addressing difficult challenges. Rather than seek to be comprehensive, either in the topics covered or in the references included, we have identified six topics:

- defining the principles for service development;
- planning and managing community mental health services;
- fostering user participation and developing advocacy;
- designing good quality services;
- building in quality safeguards;
- training for service development.

These we believe are particularly important in ensuring that current opportunities for informed change are used to maximum effect. For each topic we have described the contents of up to six publications which address the important issues and listed up to a dozen others which can be consulted for greater detail. In each case the references are listed in alphabetical order by author.

In making our selection we have concentrated on publications which deal with the design of community mental health services and the management processes required to achieve change – to the relative exclusion of documents on the financial and technical aspects of service development or the less accessible research and evaluation literature.

We expect our selections to be used selectively: readers will use the annotations to decide which publications are worth studying further in the light of issues arising on their local agenda.

Finally, this bibliography is of course only up-to-date at the time of writing in early 1988. For subsequent additions we commend the Good Practices In Mental Health Information Service, 380–384 Harrow Road, London W9 2HU. Telephone 01-289-2034 or 3060.

A. Defining the principles for service development

Throughout our work on managing transition, we have stressed the importance of basing service design and development on explicit principles which define the ways in which the lives of people with mental health problems would be changed by good services. These principles also provide, therefore, a framework for assessing service quality. This theme is repeated in each section of the bibliography as we consider, for example, planning, service design and staff training. In the first section we identify a small number of generally useful publications about aspects of the philosophy and principles upon which community-based mental health services should be built.

Key references

Braisby D, Echlin R, Hill S and Smith H. **Changing futures: housing and support services for people discharged from psychiatric hospitals**. King's Fund Project Paper 76. London, King's Fund, 1988.

This was written for staff who are responsible for resettling people in the community as long-stay psychiatric hospitals contract; or who are developing housing and support schemes for people with serious psychiatric disabilities living in hostels or with families. It distils lessons from current examples of good practice and is based on the principle of supporting individuals to live as ordinary a life as possible. It begins with a clear statement of the case for starting from values in developing a mental health service and describes how the necessary principles can be expressed in terms of measurable accomplishments for people using services. It also explores the ways in which these principles can be translated into practice.

King's Fund Centre. **Living well into old age: applying principles of good practice to services for people with dementia**. King's Fund Project Paper 63. London, King's Fund Centre, 1986.

Sets out principles in relation to developing services for elderly people with mental health problems and looks at the implications of each principle in three areas: first, for the individuals themselves; second for staff; the third, for staff as well, asks a series of questions about the principle.

Lamb H R. **Community survival for long-term patients**. San Francisco, Jossey-Bass, 1976.

Focusing on people with long-term psychiatric disabilities, this collection of papers on different aspects of treatment and rehabilitation begins with an influential and persuasive statement of principles.

MIND. **Common concern – MIND's manifesto for a new mental health service**. London, MIND, 1983.

Provides a blueprint for the development of a local comprehensive mental health service. The MIND document sets out eight principles suggesting that a local service should:

1. value the client as a full citizen with rights and responsibilities, entitled to be consulted and to have an active opportunity to shape and influence relevant services, no matter how severe his or her disability;
2. aim to promote greater self determination of the individual on the basis of informed and realistic choice;

3 aim to produce and evaluate a programme of treatment, care and support based on the unique needs of the individual, regardless of age or severity of disability;
4 aim to minimise the dependence of a client on professional resources but not allow this to be an excuse to withdraw appropriate services;
5 aim to meet the special needs arising from disability through an accessible, local, fully coordinated, multidisciplinary service offered by appropriately trained staff;
6 be easily accessible locally and delivered wherever possible in the client's usual environment;
7 plan actively for those in institutions to integrate into society if they so wish;
8 aim to enhance the individual or collective capacity to cope with or alleviate stress.

O'Brien J and Tyne A. **The principle of normalisation: a foundation for effective services**. London, Community and Mental Handicap Education and Research Association, 1981.

Translates into an accessible form the North American literature drawing on the work of Professor W Wolfensberger. It focuses on how services can demonstrate their concern for the dignity and participation of users and provides exercises which clarify important concepts.

Supplementary material

Other useful references on the principles underpinning service design and so on are included where most appropriate in the sections which follow.

B Planning and managing community mental health services

Our own work with planners and managers in England and Wales has shown that the development of new patterns of local mental health provision also requires new approaches to planning and managing the transition from current services. In relation to planning, more emphasis is required on methods which start from individual needs in the context of the level of demand suggested by locally sensitive epidemiology; more attention is needed to secure widespread participation in shaping and implementing change; and more investment is required in exploring and testing a wide variety of small-scale options for community-based provision. Similarly, the continuing management of services requires approaches which increasingly empower users, coordinate provision as far as possible on a neighbourhood basis, promote effective collaboration between the different agencies providing services and support there characteristics through appropriate strategic leadership.

Key references

Glennerster H, Korman N, and Marslen-Wilson F. **Planning for Priority Groups.**Oxford, Martin Robertson, 1983.

A study of the effectiveness of attempts by government to target resources to the priority care groups. Parts I and II consist of an account and critique of health and social services planning for elderly and mentally handcapped people in two areas. Our interest is primarily in Part III which argues not only that new and more participative planning forums are needed, but that such groups will have to find new ways of planning which can cope better with future uncertainty, encompassing the capacity to learn from experience, than traditional 'rational planning' approaches.

Kingsley S, and Towell D. **Designing local processes for service development**. In: Managing psychiatric services in transition, Working Paper 4. London, King Edward's Hospital Fund for London, 1989.

Extends Glennerster's proposal that successful service development for 'priority group' clients requires a new approach to planning. Focusing on the development of services for people with mental illness this paper proposes a model of the planning process which is participative and creative – utilising a broad range of information sources, and exploring alternative styles of service provision. It also stresses the importance of linking planning with implementation to enable experience to inform subsequent development; and demonstrates how planning detailed service packages to meet individual needs is dependent on establishing a broad framework of provision, providing a range of services.

O'Brien J. **Embracing ignorance, error and fallibility: competencies for leadership of effective services**. In: Taylor S (ed). Community integration. New York, Teachers College Press of Columbia University, 1987.

Makes the point that to learn it is necessary to admit to ignorance. In developing new ways of supporting people with disabilities it will be necessary to enable learning rather than seek blue-prints. The paper suggests ways in which service designers can create an organisational structure which has an increased capacity for learning, and in this way increase its capacity to provide effective support for people with disabilities.

Reed J and Lomas G (eds). **Psychiatric services in the community: developments and innovations.** London, Croom Helm, 1984.

A collection of conference papers which provides a wide variety of views. Coverage is comprehensive and includes contributions on the ideas which have encouraged the development of community psychiatric services; elements of an 'ideal' service; some examples of services in practice; and issues which need to be addressed for the future, and which remain topical. In addition, there is an extensive and helpfully annotated bibliography.

Towell D and Kingsley S. **Elements in a strategic framework for developing local psychiatric services.**

In: Managing psychiatric services in transition, Working Paper 3. London, King Edward's Hospital Fund for London, 1989.

Argues that achieving effective community psychiatric services requires change strategies addressed to all parts of the service system, which are grounded in clear principles. In particular this paper focuses on the links between the strategic policy framework, existing institutional services, and the development of local services. It suggests that success at local level is dependent on appropriate action by national and regional agencies, especially in relation to ensuring that financial and human resources are made available. And that a key aspect of change will require that staff of existing institutions participate in the creation of alternatives.

Towell D and McAusland T (eds). **Psychiatric services in transition: an overview.** Health and Social Services Journal, XCIV, 4919, Centre 8 Supplement, 18 October 1984. Reprinted in Managing psychiatric services in transition, Working Paper 2. London, King Edward's Hospital Fund for London, 1989.

Using contributions from several managers and practitioners involved in developing community psychiatric services this paper reviews their experience of transition and distils some key lessons. Particular issues have been developed in subsequent papers, but this supplement still provides a useful basic account and overview of transition tasks, illustrated with examples. A checklist of 20 questions to guide local action is included.

Supplementary material

Akehurst R and Holtermann S. **Provision of decentralised mental illness services: an option appraisal.** Discussion Paper No 5. University of York, Centre for Health Economics, 1985.

Audit Commission for local authorities in England and Wales. **Making a reality of community care.** London, HMSO, 1986.

Bachrach L L. **Overview: model programmes for chronic mental patients.** American Journal of Psychiatry 1980, 137, 9: 1023–1031.

Braisby D, Echlin R, Hill S, Smith H. **Changing futures: housing and support services for people discharged from psychiatric hospitals.** King's Fund Project Paper 76. London, King's Fund Centre, 1988.

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O'Brien J. **A guide to personal futures planning.** In: Bellamy G and Wilcox B (eds). A comprehensive guide to the activities catalogue: an alternative curriculum for youth and adults with severe difficulties. Baltimore, Paul H Brookes, 1987.

C. Fostering user participation and developing advocacy

The first part of this section is concerned with the involvement of service users in the planning, delivery and evaluation of mental health services. The notions of *participation* and *consultation* have grown in strength in recent years. In the NHS generally, events such as the setting up of Community Health Councils in 1974 and the consumerist strategy of Griffiths management in 1983 provide the context. This consumerist theme is also increasingly reflected in the policy debate about mental health services. Most recently, Tom Clarke's Disabled Persons Act has given considerable support to the user movement by providing for both advocacy and information. However, despite the amount of interest in participation, the literature here is quite limited.

Brandon A and Brandon D. **Consumers as colleagues.** London, MIND, 1987.

Argues the case for participation in mental health services. Presents the following incremental steps for development of user participation. Information; consultation; support in decision-making; independent representation; participation in shaping new services; gradual devolution of decision-making; finally, management by consumers. Describes two workshops on participation run for staff and service users. This pamphlet is clear, concise and well presented.

Camden Mental Health Consortium. **Mental health priorities in Camden as we see them: the consumer viewpoint.** London, CMHC, 1986. (Available from Peter Campbell, Public Relations Officer, 33 Lichfield Road, London NW2).

Both a summary of the work undertaken by Camden consortium and a questionnaire survey of consortium members. It identifies seven priority areas of need for people discharged from hospital as identified by consumers: housing, financial stability, work opportunities, day care, social and leisure activities, medical after-care and access to support in a crisis. The report presents what is currently offered by Camden in these areas, and puts forward proposals for change based on consumers' views. The report's major premise is the demand for a management structure that will listen to and act upon consumers' views of services.

Kay A and Legg C. **Discharged to the community: a review of housing and support in London for people leaving psychiatric care**. London, City University, Housing Research Group 1986. (Available from GPMH).

The results of a study of housing and support available for people discharged from psychiatric hospitals in London. Both the recipients and the providers of service were interviewed and their experiences recorded. Prominent issues highlighted by the study include confusion over professional roles, lack of coordination between agencies, haphazard and ad hoc discharge procedures, lack of user influence in the discharge procedures and users feeling powerless. The report moves on from a clear analysis of the current situation in London (from both providers' and users' viewpoints) to make practical recommendations for improvements and change.

Richardson A. **Participation**. London, Routledge and Kegan Paul, 1983.

Presents the theoretical concepts of participation, analyses the processes and explores the issues involved. It looks at recent initiatives in the statutory sector, such as health, education and housing, but does not specifically refer to mental health services. Provides a comprehensive political, legal and philosophical framework for understanding participation.

Smith H. **Collaboration for change: partnership between service users, planners and managers of mental health services**. London, King's Fund Centre for Health Services Development, 1988 (KFC 87/140). In: Managing psychiatric services in transition, Working Paper 6. London, King Edward's Hospital Fund for London, 1989.

Looks briefly at the historical background to participation in the social policy field. Explores the structure and process of collaboration, with particular reference to users' involvement. Looks at present ways in which staff can facilitate collaboration.

Winkler F. **Consumerism in health care: beyond the supermarket model**. Policy and Politics, 1987, 15, 1, January 1987: 1–8.

Critically addresses the supermarket model of consumerism in the health service. Explores other models: CHCs, democratic accountability, user power, and provider-user partnerships. Looks at the development of meaningful consumerism through the equal dispersal of power. Proposes six mechanisms to facilitate this process and illustrates how these have been developed in City and Hackney CHC.

Supplementary material

Caro F. **Reaction of a skeptical sociologist**. Community Mental Health Journal, 17, 1, Spring 1981: 77–82.

Davis A and Davis A. **Care in the community – the consumers' voice**. Community Care, 6 May 1982: 27–28.

Davis A and Towell D. **Moving out from the large hospitals – involving the people (staff and patients) concerned**. In: Care in the community – keeping it local. A report of MIND's 1983 annual conference. London, MIND, 1983.

Kenner C. **Whose needs count? Community action for health**. London, Bedford Square Press, 1986.

Koplow L. **Client participation in mental health service delivery**. Community Mental Health Journal, 17, 1, Spring 1981: 46–53.

Lorefice L S and Borus J F. **Consumer evaluation of a community mental health service: perception of clinical care**. American Journal of Psychiatry, 1984, 141, 11: 1449–1452.

Palmer E. **Consulting the consumer: an attempt in Newcastle-Upon-Tyne**. 1986 (Available from Human Services Training Agency, 135 Sandyford Rd, Newcastle-Upon-Tyne, NE2 1QR).

Raphael W. **Psychiatric hospitals viewed by their patients**. London, King Edward's Hospital Fund for London, 1977.

Windle C and Cibulka J. (1981) **A framework for understanding participation in community mental health services**. Community Mental Health Journal, 17, i, Spring 1981: 4–18.

The second part of this section deals more specifically with *advocacy*in mental health services. The advocacy movement has been pioneered in relation to mental handicap services. The development of a comparable movement in the mental health services is very recent and the emphasis has been much more on self advocacy than on citizen advocacy. There are now well established user groups and they are growing. September 1987 saw the first user-run conference which was able to review the situation nationally and look at future directions for the movement.

Key references

Barker I and Peck E (eds). **Power in strange places: user empowerment in mental health services**. London, Good Practices in Mental Health, 1988.

Presents a range of initiatives concerned with user participation in mental health services. Their strategies include a partnership approach to management of a statutory project; a campaigning alliance of service users, providers and carers and the impact on statutory planning processes; the adaptation of experiences in Holland to British services; and the development of a national network of self-advocacy groups. The editors place these practical developments within a theoretical base of consumerism, advocacy, and rights and representation.

Good Practices In Mental Health. **Advocacy information pack: advice and advocacy services for people with psychiatric disabilities**. London, GPMH, 1986.

A collection of papers looking at issues and principles in advocacy. Describes a number of legal and welfare advice projects.

Nottingham Advocacy Group. **Project pack**. 1986 (Available from Nottingham Patients Council Support Group, c/o MIND, 114 Mansfield Road, Nottingham).

Includes the following papers:

(i) *The Nottingham Project*. Detailed proposal strongly arguing for the involvement of users in psychiatric services. Proposes a tripartite scheme to provide effective advocacy and participation for users. Scheme consists of patients' councils, paid advocates and citizen advocates, and is based on Dutch clients movement. Includes the constitution of the Nottingham Patients Council Support Group and a detailed analysis of resource implications. Provides both information and advice, and would be particularly useful for those wishing to develop similar projects.

(ii) *Report on Study Tour of the Clients Movement in Holland*. Briefly describes the patients councils, patients advocates and clients union, presenting the background, current situation and future aspirations of these groups.

(iii) *Patients Rights Advocacy: The Dutch Model*(by Johan Legemaat). A detailed description of the development of patients advocacy set in the context of the mental health services in the Netherlands. Concludes with a discussion on the role of the patient advocate.

(iv) *Mapperley Advice Project: The First Year's Work*. Presents the legal and welfare advice service that is being offered in Mapperley Hospital. The project is independent of the hospital and run by trained staff. This evaluation includes examples of casework and discusses future developments.

Rose S and Black B. **Advocacy and empowerment. Mental health care in the community**. London, Routledge and Kegan Paul, 1985.

The first section presents an alternative perception of mental health service delivery. Drawing heavily on the work of Paulo Freire, the authors examine how the current system oppresses and 'submerges' service users. Puts forward their different approach based upon advocacy and empowerment of people. The second section explores how the authors have used this approach in five areas of mental health care – case management, day programs, legal advocacy, program evaluation and community organisation. Although based on American mental health services, the theories and practices apply universally.

Supplementary material

Brandon D. **Voices of experience: consumer perspectives of psychiatric treatment**. London, MIND, 1981.

Gibbs A. **Understanding mental health**. London, Hodder and Stoughton for Consumers Association, 1986.

Gostin L. **Advocacy: turning rights into action**. London, MIND Publications, 1979.

Springfield Advice and Legal Representation Project and Social and Community Planning Research. **The advice and legal representation project at Springfield Hospital 1982–85 – an evaluation**. King's Fund Project Paper 59. London, King Edward's Hospital Fund for London, 1986.

Milner E. **The symbols and meaning of advocacy**. International Journal of Law and Psychiatry, 1986, 8, 1: 17.

Pelletier J, Rogers S and Thurer S. **The mental health needs of individuals with severe physical disability: a consumer advocate perspective**. Rehabilitation literature, 1985, 48, 7/8: 186–193.

D. Designing good quality services

The references in this section have been chosen mainly to illustrate aspects of community care for people with long-term serious mental illness. People in this category usually have continuing contact with mental health services. They may have spent many years on a long-stay ward or have a history of repeated admissions. Although other groups with mental health problems have a claim on community services, the American experience with community mental health centres (CMHCs) has taught us that the needs of people with long-term problems are easily overlooked, so we have given them priority.

The references selected are categorised under functional headings for two reasons. First, people with long-term problems have wide needs. As well as treatment for their mental health problems, they also need housing, an income, personal relationships, something to do during the day, leisure opportunities, attention to physical health problems and so on. Second, focusing on service functions may lead to more imaginative ways of planning to meet needs. There is a tendency to visualise future services in terms of existing buildings (day centres, hostels) or existing service organisation (psychiatry, nursing) rather than in terms of what the service should achieve for people.

The exceptions to the functional categories are CMHCs and some special groups, such as people with dementia or with alcohol problems. CMHCs are given a separate category because there is currently a high level of interest in them but no consensus about their role. Some special groups, currently receiving separate, specialist services or underserved, are given their own categories in order to draw attention to them.

A positive effort has been made to choose references which are consistent with the principles outlined earlier in the bibliography, although some pragmatic choices have been made. For example, authors of earlier books paid little or no attention to empowering service users but it is still possible to learn a lot from their approach to designing comprehensive services

Key references only

Prevention

Newton J. **Preventing mental illness**. London, Routledge and Kegan Paul, 1988.

A review of the literature on prevention. The book looks at what is known about the distribution and causes of mental illness and at the factors which could be changed to prevent it. Preventive strategies are discussed, particularly in relation to schizophrenia and depression, and focusing on social factors. The book goes on to examine the reported evidence that certain types of social intervention can change the rates of mental illness. For example, can artificial support systems prevent depression? This is followed by a discussion of the risk factors inherent in certain social roles, for example, being a woman or unemployed, and the effectiveness of interventions in childhood to prevent mental illness. Finally, the implications for practice and problems in implementing preventive strategies are discussed.

Primary health care

Clare A W and Lader M (eds). **Psychiatry and general practice**. London, Academic Press, 1982.

The role of the general practitioner in mental health services and the relationship between primary care and secondary services. This covers: the ability of GPs to identify and respond effectively to various types and degrees of psychological problem; typical interventions, such as counselling/medication and referral to other primary care workers, the counsellor or the social worker; and the links between psychiatrists and GPs.

The book does not cover the training of GPs in mental health in any depth or the role of GPs in the care of people with long-term problems.

Crisis intervention/crisis management

Aguiler D C and Messick J M. **Crisis intervention: theory and methodology**(3rd Edition). St Louis, CV Mosby, 1978.

A good basic overview covering a broad range of crises, including relapse in long-term mental illness, with reference to all the classical theoretical texts.

Bouras N and Tufnell G. **Mental Health Advice Centre: the crisis intervention team**. London, Lewisham and North Southwark Health Authority, 1983. (Research report No 2) Available from NUPRD, Lewisham Hospital, Lewisham High Street, London SE13 6LH.

A description of the service, which is part of a community-based psychiatric service, and an analysis of referrals. This team provides a service to people with severe and long-term mental illness.

Cooper J E. **Crisis admission units and emergency psychiatric services: report on a study**. Copenhagen, World Health Organization, Regional Office for Europe, 1979.

Describes a selection of services in Europe with a brief review of the literature and discussion of implications for planning.

Davis A et al. **Coventry Crisis Intervention Team: the consumer's view**. Social Services Research, 14, 1, 1985: 7–32.

An article describing a small-scale survey conducted by the team into consumers' views of the service they provide. The survey led to a significant change in the operation of the service – the introduction of longer-term support. Consumer feedback is seen as vital if community services are to escape from the out-dated practices associated with institutions.

Newton S, Pidd F and Smith D. **Crisis intervention: review of theory and practice**. Coventry, Coventry Crisis Intervention Team, 1987. Available from 36 St Paul's Road, Foleshill, Coventry CV6 5DF.

A detailed description of the history and operation of this social services team which has access to a residential facility. Experience has led to the reworking of the traditional crisis model and the team now offers long-term support to clients without social networks to fall back on. There is also a section on monitoring and evaluation and an extensive reading list.

World Health Organization Regional Office for Europe. **Working group on crisis intervention and psychiatric emergency services in Europe: summary report**. Copenhagen, WHO, 1985.

A review of the experiences of a representative sample of crisis and psychiatric emergency services in Europe with recommendations on the organisation and functions of such services within a comprehensive mental health service system. This article provides a useful overview of crisis services. The emphasis on crisis intervention as part of the community mental health system, rather than as a separate service development, is useful and reflects current developments in crisis intervention.

Community mental health teams and centres

Boardman A P, Bouras N and Cundy J. **The Mental Health Advice Centre in Lewisham. Service Usage:**

trends from 1978 to 1984. London, National Unit for Psychiatric Research and Development, 1987. Available from NUPRD, Lewisham Hospital, Lewisham High Street, London SE13 6LH.

This is a decentralised psychiatric service which is an accepted route into the mental health system, unlike other CMHCs which are frequently alternatives to the existing system. The centre comprises a walk-in service offering individual counselling and advice, a crisis intervention team and a rehabilitation team for people with longer-term needs.

Brown P. **The transfer of care: psychiatric deinstitutionalisation and its aftermath**. London, Routledge and Kegan Paul, 1985.

Chapter 3 is a historical overview of the American CMHC movement. It outlines the initial optimism surrounding CMHCs, their rapid expansion and eventual eclipse, as well as an anaylsis of what went wrong. The book as a whole is a critique of the current mental health care system in the USA, but some important lessons can be learnt by British CMHCs.

Good Practices in Mental Health/Interdisciplinary Association of Mental Health Workers. **Community mental health centres and teams: information pack**. London, GPMH/IAMHW, 1988.

Contains a number of articles on the issues involved in planning and running a CMHC, descriptions of projects, and a directory of CMHC/Ts. The issues identified include planning and targeting CMHCs, interdisciplinary work, team organisation and management, and working with the community and with other agencies/professionals and involving users. These articles illustrate the diversity of services developing under the CMHC umbrella. Although there is disagreement about appropriate functions, there do appear to be common styles and methods of working.

McAusland T (ed). **Planning and monitoring community mental health centres: collected papers**. London, King's Fund Centre (KFC 85/61), 1985.

Collected papers which again demonstrate the variety of services operating under this title.

Stein L and Test M (eds). **The training in community living model: a decade of experience**. New Directions for Mental Health Services No 26. New York, Jossey-Bass, 1985.

Describes a successful programme, based entirely in the community, which offers intensive treatment and support to people with severe and long-term mental health problems. People are helped through the provision of special supports and direct assistance to community living skills. Also contains articles on the replication and cost-benefit analysis of this model. Very useful to planners because of its implications for 'bed' provision.

Day services

Carter J. **Day services for adults: somewhere to go**. London, George Allen and Unwin, 1981.

A report of a national survey of adult day care services carried out by the National Institute of Social Work. The book is not primarily concerned with mental health services and some sifting of the material is necessary to draw out the relevant ideas. A useful chapter on day care for mentally ill people compares health service day hospitals with local authority day centres and finds considerable similarities. The chapters on rehabilitation and sheltered work, which question conventional wisdom about aims and outcomes, are also worth looking at.

Good Practices in Mental Health. **Day care information pack**. London, GPMH, 1987.

Looks beyond day centres to the components of a comprehensive day care service for people with long-term disabilities. Articles on a number of innovative, outward-looking projects, including Peter Bedford Trust, London, North Derbyshire Mental Health Services Project, Chesterfield and Fountain House, New York.

Lamb H R. **Treating the long-term mentally ill: beyond deinstitutionalization**. San Francisco, Jossey-Bass, 1982.

Still one of the best books on developing community treatment and rehabilitation services for people who are severely disabled by long-term mental illness. There are useful chapters on groups which are under-served, such as young adult long-term patients, mentally ill offenders and people with very aggressive or disturbed behaviour. A chapter on case management puts forward the view that coordination is best achieved by the therapist.

Patmore C (ed). **Living after mental illness: innovations in services**. London, Croom Helm, 1987.

The common thread running through this book, in which many innovative projects are described, is enabling recovery from mental illness to take place outside the four walls of hospitals and mental health centres by working directly on opportunities and existing resources in the individual's everyday life. The book covers rebuilding and supporting family networks, enhancing opportunities for employment, innovative approaches to sheltered and occasional work, as well as leisure opportunities. Although primarily concerned with rehabilitation, there is a special focus on changing the organisation and delivery of day care services.

Shepherd G. **Institutional care and rehabilitation**. London, Longman, 1984.

This short, highly readable book covers the general principles of rehabilitation, the elements of a comprehensive community service, quality of care, creating organisational change and future trends in rehabilitation. Useful for planners who have to know what frontline staff need to do.

West M. **A real job, a real chance**. Social Services Insight, 1, 8, February 1986: 20–21.

An article assessing the MSC-funded sheltered placements scheme, which provides long-term work opportunities for disabled people. The scheme looks as though it may provide long-term work for people with mental health problems, but, as yet, there are too few experiences on the ground to assess its relevance to mental health.

Wing J K and Morris B (eds). **Handbook of psychiatric rehabilitation practice**. Oxford, Oxford University Press, 1981.

Assorted papers covering the contribution made by different disciplines to rehabilitation services, the functions of rehabilitation units and some service examples

Housing

Bayliss E. **Housing: the foundation of community care**. London, MIND and National Federation of Housing Associations, 1987.

This book is concerned with the technical aspects of developing ordinary housing. It has useful sections on strategies for joint planning, development, management, staffing and finance. This is very well presented: the complexities of planning and developing ordinary housing are made clearer with the help of many tables, summaries and examples. Should be read in tandem with 'Changing Futures' to get an overview of the field.

Braisby D, Echlin R, Hill S and Smith H. **Changing futures: housing and support services for people discharged from psychiatric hospitals**. King's Fund Project Paper 76. London, King's Fund Centre, 1988.

This book sets out five accomplishments, or outcomes, which should be achieved for individuals by mental health services. It then discusses ways in which housing and support services might be developed which achieve these outcomes. Although there is some discussion of the technicalities of developing housing, the main emphasis is on the delivery of care and the implications for staff of working in the community.

Good Practices in Mental Health. **Housing information pack: ordinary housing for people with major long-term psychiatric disabilities**. London, GPMH, 1985.

Examines the option of ordinary housing for people discharged from long-stay psychiatric hospitals and the type and level of support services it requires. The pack contains descriptions of a number of schemes, including the Hackney Community Psychiatry Research Unit; Waltham Forest Community Project; and Leicester Community Accommodation Project. It also contains notes on finance and training and a directory of related schemes.

Hennigan M and Dumaresq D. **The Camden adult care scheme**. Social Work Service, 15, May 1978: 19–22.

A brief description of this well known scheme. A footnote gives a landlady a chance to describe the scheme as she sees it.

MIND South East. **Housing bibliography**. MIND South East Housing Service, 1988. Available from MIND South East Housing Service, Fourth Floor, 24–32 Stephenson Way, London NW1 2HD.

A very detailed reading list which concentrates on the technical aspects of housing provision for mentally ill people.

Vousden M. **Caring on the coast**. Nursing Mirror, 160, 6, 6 February 1985: 20–25.

Describes the hospital hostel in Southampton.

Income support

Bradshaw M and Davis A. **'Not a penny to call my own': poverty amongst residents in mental illness and mental handicap hospitals**. London, Disability Alliance and King Edward's Hospital Fund for London, 1986.

Examines the reasons for povery in long-stay hospitals and suggests action to combat it.

Brook E. **Mental health and welfare rights: network directory**. 1987. Available from Eve Brook, Social Administration Department, University of Birmingham, PO Box 363, Birmingham B15 2TT.

A directory of projects which offer welfare rights or legal advice to people in psychiatric hospitals. Many have initiated successful benefit take-up campaigns.

Burningham S. **Where patients may lose out**. Health and Social Services Journal, XCIV, 4924, 22 November 1984: 1386–1387.

An overview of welfare rights projects attached to hospitals, suggesting innovative ways of increasing take-up.

Good Practices in Mental Health. **Advocacy information pack: advice and advocacy services for people with psychiatric disabilities**. London, GPMH, 1986.

Mainly concerned with projects which offer advice on income maintenance to people in hospital, but it also covers legal representation.

Springfield Advice and Legal Representation Project and Social and Community Planning Research. **The advice and legal representation project at Springfield Hospital 1982–1985 – an evaluation**. King's Fund Project Paper 59. London, King Edward's Hospital Fund for London, 1986.

Services for older people

DHSS. **Home life: a code of practice for residential care**. London, Centre for Policy on Ageing, 1984. Available from Centre for Policy on Ageing, 25–31 Ironmonger Row, London EC1V 3QP.

Provides guidance to health and local authorities on approving and inspecting private and voluntary residential care homes for registration under the 1984 Registered Homes Act. Includes a good practice checklist.

Challis D et al. **A new life at home**. Community Care, 455, 24 March 1983: 21–23.

The Gateshead community care scheme aims to care for frail elderly people, some with dementia, in their own home. An innovative feature is that direct care workers are also budget-holders.

King Edward's Hospital Fund for London. **Living well into old age: applying principles of good practice to services for people with dementia**. King's Fund Project Paper 63. London, King's Fund Centre, 1986.

This important publication develops a system of values and applies them to a challenging service area. Although lacking specific examples of good practice, it discusses extensively the implications for individuals, frontline staff, managers and planners of putting these values into operation, making it relevant to service design. Also included are useful sections on the experience of dementia from the point of view of the individual and their carer(s) and a section on developing an advocacy service for people with dementia. Some advice is given on how individual staff at district level can bring about change by building coalitions between key people in other parts of the service or in other agencies.

Lodge B. **Coping with caring: a guide to identifying and supporting an elderly person with dementia**. London, MIND, 1981.

Especially useful for its clear and concise descriptions of mental health problems that may arise in old age. Recommended for training in assessment.

Murphy D and Rapley C F. **Still living at home**. Community Care, 622, 31 July 1986: 25–27.

Looks at the successes and problems of the joint Age Concern/Guy's Hospital research project to provide flexible packages of care for elderly mentally ill people living at home.

Norman A. **Severe dementia: the provision of long-stay care**. London, Centre for Policy on Ageing, 1987.

Fourteen detailed case studies of residential establishments, ranging in size from 8–30 beds, run by health services, social services and the private sector. There are good background chapters on service provision and on issues in service design, operation and management. Alison Norman's experience and knowledge of the field make this essential reading.

Smith P. **Home support for elderly mentally infirm people**. London Centre on Environment for the Handicapped, 1984. Available from CEH, 35 Great Smith Street, London SW1P 3BJ

A number of innovative schemes, designed to support people with dementia in their own homes, are described in this report of a seminar. They include the Liverpool domiciliary aid scheme and the Napsbury 24-hour psychogeriatric crisis team.

Willcocks D, Peace S and Kellahar L. **Private lives in public places: a research-based critique of residential life in local authority old people's homes**. London, Tavistock, 1987.

This very readable text develops a model of residential care based on data from the National Consumer Study in 100 local authority old people's homes. It is not concerned with people with dementia, but is worth reading for the detailed discussion of better design of physical environments.

Black and Ethnic Minorities

Renshaw J. **Mental health care for ethnic minority groups**. London, GPMH, 1988.

Ward L. **A descriptive bibliography of articles and books on black and ethnic community mental health in Britain**. London, MIND, Black and Ethnic Minority Development Team, 1987.

A very comprehensive list of articles, books and unpublished material which covers cultural issues, racism, service take-up and usage. An index based on ethnic grouping adds to the list's potential usefulness.

Services for people with alcohol problems

DHSS and Welsh Office. **The pattern and range of services for problem drinkers: report by the Advisory Committee on Alcoholism**. London, DHSS, 1978.

Good Practices in Mental Health/Alcohol Concern. **Alcohol services information pack**. London, GPMH, 1986.

Provides a general overview of alcohol services.

Shaw S, et al. **Responding to drinking problems**. London, Croom Helm, 1978.

Although written some time ago, this important text provides the theoretical basis for community alcohol teams.

E. Building in quality safeguards

The challenge of creating community based psychiatric services is not simply to move services out of institutions, but rather to make a significant improvement in the quality of what is offered. The references in this section cover descriptions of quality in mental health services – especially from the users' viewpoint – and ways that organisation development processes can contribute to strategies for developing a more quality conscious service. Some references are specific to mental health services, but others use examples drawn from different fields where long-term care is a particular issue.

Key references

Bachrach L L. **Principles of planning for chronic psychiatric patients: a synthesis**. In: Talbot J A (ed). Chronic mental patients: five years later. New York, Grune and Stratton, 1984.

Based on a review of the experience of deinstitutionalisation in the USA, this draws out nine key principles which need to be recognised in developing community services that will meet the needs of chronically ill patients. These are setting goals and objectives; identifying priorities; re-assessing the place of institutions in community care systems; ensuring a range of services; establishing inter-agency cooperation; individual programme planning; cultural relevance in service provision; modifiable systems; and exercising caution and restraint.

Brandon A and Brandon D. **Consumers as colleagues**. London, MIND, 1987.

This short pamphlet outlines the value of increasing consumer participation in service design and delivery, and goes on to give examples from two study days the authors ran in different mental hospitals. The results have implications for the development of services which will be relevant to a much wider audience, and these are drawn out in a concluding chapter. The main message is that quality services which are enabling will not be possible until the power structures which maintain the present organisation of services are confronted and dismantled, providing service users with real opportunities for autonomy and decision making.

Independent Development Council for People with Mental Handicap. **Pursuing quality: how good are your local services for people with mental handicap?** London, IDC, 1986. Available from King's Fund Centre, 126 Albert Street, London NW1 4NF.

Although this booklet focuses on services for people with mental handicap it is a key text, raising important questions and giving examples of approaches which will be relevant to all long-term care services. After describing the main elements of 'quality' – relevant across client groups – there is a discussion of how to develop a quality approach to service development which relies on 'bottom-up' planning and wide involvement. These principles are reflected in the following section which is a step-by-step guide to forming a quality action group (similar to the quality circle concept). Finally there are a number of examples of services which have pioneered the approach recommended.

King Edward's Hospital Fund for London. **Living well into old age: applying principles of good practice to services for people with dementia**. King's Fund Project Paper 63. London, King's Fund Centre, 1986.

This paper provides an excellent example of how service quality can be assessed on the basis of key principles which form specific aspirations for service delivery. The method is adaptable to any service, but is especially pertinent to services providing long-term care and support. In particular there is a useful section which demonstrates how abstract principles can be translated into measurable service outcomes, and the implications of this for management.

Mansell J et al. **Bringing people back home: South East Thames Regional Health Authority's staff training initiative in mental handicap**. Bristol, National Health Service Training Authority, 1987.

While this document concentrates on staff training and provides a useful model of how a regional initiative can be used to stimulate and support local development, it also includes an important chapter on quality assurance. There are two key concepts around which the discussion is built. Firstly, that quality assurance is an important mechanism for sustaining the impetus of improvement and service development, which so often decays rapidly. Second, that quality assurance should not be regarded as a technique to be imposed; rather, it is about changing the 'culture' of the service so that every person is committed to innovation and improvement.

Shepherd G. **Institutional care and rehabilitation**. London, Longman, 1984.

See especially Chapter 4: Quality of Care. Within the context of a discussion of care for long-term mental health service users, quality is described as a result of a complex interaction of factors not achievable by simple, unidimensional changes. The different variables discussed include size, staffing, physical facilities, organisation and management, staff-client interaction, and staff support. Key aspects of quality identified are individual centred care programmes; staff involvement in decision making; and ensuring novelty and change.

Supplementary material

DHSS. **Home life: a code of practice for residential care**. London, Centre for Policy on Ageing, 1984.

Clephane H and Pullen I. **Rehabilitation in the community: an introductory handbook**. Edinburgh, Churchill-Livingstone, 1986.

Davies L. **Quality, costs and 'An Ordinary Life': comparing the costs and quality of different residential services for people with mental handicap**. King's Fund Project Paper 67. London, King Edward's Hospital Fund for London, 1987.

Huxley P. **Quality measurement in mental health services: a discussion paper on quality of life measurement**. London, Good Practices in Mental Health, 1986.

Jones K. **After hospital: a study of long-term psychiatric patients in York**. Department of Social Policy and Social Work, University of York, 1985.

Kagan R M. **Organisational change and quality assurance in a psychiatric setting**. Quality Review Bulletin, September 1984.

Robertson A and Osborn A (eds). **Planning to care: social policy and the quality of life**. Aldershot, Gower, 1985.

Shepherd G. **Planning the rehabilitation of the individual**. In: Watts F and Bennet D (eds). Theory and practice of psychiatric rehabilitation. London, Wiley, 1983.

Smith H. **Safeguarding community care: the American experience**. (A report from a seminar held at the King's Fund Centre on 11 July 1986.)

Towell D. **Achieving and maintaining quality in community based services**. In: Achieving high quality community based services for people with learning disabilities in the South West. Bristol, South Western Regional Health Authority, 1986.

Ward L (ed). **Getting better all the time? Issues and strategies for ensuring quality in community services for people with mental handicap**. King's Fund Project Paper 66. London, King Edward's Hospital Fund for London, 1987.

F Training for service development

The transition to community-based mental health services has highlighted more than ever the importance of the human (as opposed to capital) resources in the health service. New patterns of service delivery and models of care imply new roles for existing staff. Training will be essential if staff are to meet the challenge of working in the community with confidence and competence.

The references that have been selected for this section emphasize the following points.

- The need for a coherent training strategy that involves relevant statutory agencies, voluntary organisations and user groups.
- A strategy that emphasises an inter-agency and interdisciplinary approach.
- Training that is based both in the needs of the services (and is therefore linked closely to planning and design) and in the personal development needs of individual staff.
- Most importantly, training that has a clear value base which reflects the way the service works with staff and the way staff are being trained to work with users. The value base should inform the service design and the training strategy.

Key references

Andrew D and Zutshi H. **The Alice in Wonderland game**. Effective use of games and simulations, 10, 1985: 113–119. Society for the Application of Games and Simulation in Education and Training, c/o D. Saunders, Department of Communication Studies, Polytechnic of Wales, Pontypridd CF37 1DL.

An exercise that shows how important it is to design training programmes which start by considering the service needs they are aiming to fulfil. Used with a group of mental health service managers, it demonstrates how people need to be involved in determining their own training needs and how service users might train staff to meet their needs.

Bassett T. **Training for transition: a report written for Cambridge Health Authority**. Brighton, East Sussex Consultancy and Training Agency, 1987. Available from 6 Pavilion Parade, Brighton BN2 1RA.

Details a joint training strategy for health authorities and social services. Aims to enable staff to develop models of care appropriate for community mental health services. Both the training strategy and the suggested programme are described. Also includes financial and resource implications of the exercise.

Boydell T H. **A guide to the identification of training needs** (2nd edition). London, British Association for Commercial and Industrial Education, 1976.

Links organisational, occupational and individual training needs. Describes how training needs in industry can be traced back from desired output goals, which may be seen as analogous to service aspirations. Particularly helpful as a concise account of different levels and styles of learning together with different levels and styles of training interventions. Highly relevant for anyone involved in designing a training strategy to support transition to community based mental illness services.

Kingsley S and Smith H. **Values for change**. London, King's Fund Centre, 1989.

Proposes a model training strategy which starts by identifying training needs from service development proposals and links training for front-line staff with training for managers. Includes sections on the values and issues in service development and values underpinning an approach to training. Addresses knowledge and attitudes as well as skills. Gives examples of some of these ideas in practice.

National Health Service Training Agency. **Creating a framework for health pickup: an outline of the training needs analysis project**. Bristol, NHSTA, 1986.

Details the major programme for the continuing education and training of NHS professional staff. Describes a modular design based on service needs and personal development needs. Aims to provide a coherent strategy for mid-career training.

Higham M. **Training structures in the NHS: a working paper**. Leeds, Training in Health and Race, 1985. (Now available from the NHSTA)

Provides a brief but comprehensible introduction to the organisational structure of the NHS and the organisations and individuals in it that are responsible for training (for example, NHSTA RETO). It details training for managers, the medical and the nursing professions. Training and research in multiracial health care is also briefly discussed.

Supplementary material

Basset T. **Tread softly: a one-day video-assisted workshop looking at transition from large psychiatric hospitals to local community services**. Brighton, East Sussex Consultancy and Training Agency, 1984.

Brown H and Alcoe J. **Lifestyles for people with mental illness: a staff training exercise based on normalisation principles**. Brighton, East Sussex Consultancy and Training Agency, 1984.

Housing Support Team. **Preparing for change: a manual of training materials**. London, Housing Support Team, 1985. Available from the team at North Lambeth Day Centre, 64/66 Newington Causeway, London SE1 6DF.

National Health Service Training Authority. **Services for people with mental handicap: human resource issues**. Bristol, NHSTA, 1986.

National Health Service Training Authority. **Challenging complacency in National Health Service training**: the report of an NHS working group examining the strategic role of planned training in managing change. Bristol, NHSTA, 1986.

South East Thames Regional Health Authority. **Bringing people back home**. Tunbridge Wells, SETRHA, 1985.

Shearer A (ed). **An Ordinary Life: issues and strategies for training staff for community mental handicap services**. King's Fund Project Paper 42. London, King's Fund Centre, 1983.

Todd F. **Planning continuing professional development: planning to improve performance.** A handbook for education facilities. York, University of York NHS Continuing Education Unit, 1985.

Ward L. **Planning for people: developing a local service for people with mental handicap. 1 Recruiting and training staff**. King's Fund Project Paper 47. London, King Edward's Hospital Fund for London, 1984.

Ward L and Wilkinson J (eds). **Training for change: staff training for 'An Ordinary Life'**. London, King's Fund Centre, 1985.

Managing psychiatric services in transition: working papers

Since 1983, the King's Fund College has been mounting a programme of educational and field development activities designed to assist networks of local people in addressing the challenges involved in managing psychiatric services in transition. These papers detail key lessons from this work. While not aspiring to be comprehensive, the papers do suggest a systematic framework for planning and implementing new patterns of psychiatric provision and discuss key elements of local strategies in detail. The papers have been prepared by David Towell, Su Kingsley and Tom McAusland, with assistance from Helen Smith at the King's Fund Centre for Health Service Development and Rose Echlin of Good Practices In Mental Health. The College's work between 1983 and 1987 received financial support from the DHSS and NHS Training Authority.

This work is continuing through the College's Building Community Strategies Group and information on current activities is available from its Programme Support Unit.

David Towell is Fellow in Health Policy and Development at the College and leader of the Building Community Strategies Group.

Su Kingsley was a College Associate (1984–7) and is now Assistant General Manager responsible for mental health services, Haringey District Health Authority.

Tom McAusland was Project Officer at the King's Fund Centre (1982–86) and is now Senior Project Officer in the service development and evaluation team, Exeter District Health Authority.

1 A guide to using the working papers and checklist for action

2 Managing psychiatric services in transition: an overview

3 Elements in a strategic framework for developing local psychiatric services

4 Designing local processes for service development

5 Assessment, rehabilitation and resettlement: designing the arrangements for moving people from psychiatric hospitals into local services

6 Collaboration for change: partnership between service users, planners and managers of mental health services

7 Annotated bibliography

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