

# A Partial Solution: a Local Mental Health Authority for the UK

Trevor R. Hadley<sup>1\*</sup> and Howard H. Goldman<sup>2</sup>

<sup>1</sup>Center for Mental Health Policy and Services Research, University of Pennsylvania, 3600 Market Street, Room 717, Philadelphia, PA 19104-2648, USA

<sup>2</sup>Department of Psychiatry, University of Maryland, 645 West Redwood Street, Baltimore, MD 21201, USA

## Abstract

**Background:** the structural problems of the mental health system in the UK have been analyzed by a number of authors over the past several years as the 'reforms' of the health and social service systems have continued (Kavanagh and Knapp, 1995; Mechanic, 1995). In a recent article, Hadley and Goldman (1995) suggest that one possible solution to some of these issues may be the creation of a local mental health authority. Such an authority would consolidate the funding, authority and responsibility in a single entity. We believe this model, which is typical of many local public mental health systems in the US, is at least part of the solution to the current problem of financial and service fragmentation of the current system in the UK.

The numerous 'reforms' of the health and social service systems (which include the Community Care Act, the development of the Internal Market, GP fundholding and the purchaser-provider split) were not designed for the care of the mentally ill (Han, 1996). These policy changes in the design of health and social services have created a complicated and difficult context in which services must be delivered.

Too many agencies play a significant role in the delivery and management of mental health services. Health authorities, social service agencies and GP fundholders are direct and indirect funders of the system while community care trusts, social service agencies and GPs are service providers (Hadley, 1996a).

**Results and a Proposal:** We believe that the development of local mental health authorities may be part of the solution to the structural and economic problems of the current system in the UK. It is not the answer to limited resources or limited skills, but can create a new structure, which will permit and encourage the cooperation and innovation that is now possible only with unusual effort. Local mental health authorities have a number of crucial characteristics, but, most importantly, they refocus the system on the provision of care to the seriously mentally ill. This is the expressed priority of government, advocates and providers, alike.

These new entities could be created at either the purchaser or provider level or, as exists in a number of jurisdictions in the US, at both levels, where a single purchaser may be responsible for multiple consolidated providers. This combination is now the emerging model for innovative services in the US. In the UK, the development of a local mental health authority at the purchaser and/or provider level might be relatively simple. Although the creation of a statutory authority would require primary legislation and is therefore probably not a short-term solution, there appears to be a variety of administrative options that would have the same effect.

**Implications for Health Policy Formulation:** The creation of a local mental health authority may be a necessary first step towards the development of a coordinated and comprehensive system of care. It seems likely that there is currently more 'political' support for the development of a purchaser model but the development of a sophisticated purchaser is also likely to take considerable time and effort. Although all the structural and policy problems of the mental health system in the UK will not all be solved by local mental health authorities, they may be beneficial if responsibility for mental illness care is to be centralized and fragmentation is to be reduced. Without making structural changes, the best efforts by clinicians, policymakers and managers are most likely to be in vain. Without a clear point of ultimate purchasing and service responsibility, the fragmentation and inefficiency of the current system will remain (Hadley *et al.*, 1996) © 1998 John Wiley & Sons, Ltd.

Received 27 November 1997; accepted 17 April 1998.

## Introduction

The structural problems of the mental health system in the UK have been analyzed by a number of authors over the past several years as the 'reforms' of the health and social service systems have continued (Kavanagh and Knapp, 1995; Mechanic, 1995). In a recent article, Hadley and Goldman (1995) suggest that one possible solution to some of these issues may be the creation of a local mental health authority which would be responsible for all mental health services for a geographic area. Such an authority would consolidate the funding, authority and responsibility in a single entity. We believe this model, which is typical of many local public mental health systems in the US, is at least a part of the solution to the current problem of financial and service fragmentation of the current system in the UK.

The numerous 'reforms' of the health and social service systems (which include the Community Care Act, the development of the internal market, GP fundholding and the purchaser-provider split) were not designed for the care of the mentally ill (Han, 1996). These policy changes in the design of health and social services have created a complicated and difficult context in which services must be delivered.

Too many agencies play a significant role in the delivery and management of mental health services. The responsibilities for the planning, financing and delivery of care are split between four parties, all of whom have some

\* Correspondence to: Trevor R. Hadley, Ph.D. Director, Center for Mental Health Policy and Services Research, University of Pennsylvania, 3600 Market Street, Room 717, Philadelphia, PA 19104-2648, USA.  
Source of funding: none

responsibility and investment in the care of persons with mental illness. However, their interests are quite different and often conflicting (Muijen, 1995). Health authorities, social service agencies and GP fundholders are direct and indirect funders of the system while community care trusts, social service agencies and GPs are service providers. It should be noted that each GP or GP practice may in fact have differing priorities (Hadley, 1996a).

The level of discontent in the system has risen in recent months with the repeated findings from official inquiries into the failure to provide adequate community supervision and continuity of care for individual users. The level of fragmentation is not only confusing and frustrating to the participants, but clearly creates a level of conflict that cannot be productive for the care of the mentally ill (Muijen, 1996). In addition to the problems with coordination and conflicting priorities, the multiple and conflicting incentives in the mental health system are also creating inefficiencies in the management of scarce and highly valued resources (Hadley, 1996a).

Clearly, some changes are necessary. Determining the future relationship among GP fundholders, health authorities, community care trusts and local authorities must be of major interest to future policy makers.

## **A Local Mental Health Authority**

We believe that the development of local mental health authorities may be part of the solution to the structural and economic problems of the current system in the UK. It is not the answer to limited resources or limited skills, but can create a new structure which will permit and encourage the cooperation and innovation which is now possible only with unusual effort and resolve. The changes may require new and expanded resources. Likewise, the continued cooperation of professionals, managers, users and caregivers will also be critical to the long-term health of the system. Local mental health authorities have a number of crucial characteristics, but, most importantly, they refocus the system on the provision of care to the seriously mentally ill. This is the expressed priority of government, advocates and providers, alike.

What are local mental health authorities and how can they help? Local mental health authorities have a long history in the delivery of mental health services in a number of countries around the world. Basically, they are organized structures that are primarily responsible for the centralized development, management and delivery of mental health services to a defined geographic population. Such authorities may organize and deliver the services, or commission the services. These entities are often public or semi-public structures which are identified by government as the responsible party for mental health services in that area. There are various ways that such local entities may be organized and managed. In some parts of the United States, these entities are run by local county or city governments. In other places, these entities are private, non-profit organizations which are funded by the government. In general, they

have been successful in the creation of better coordination of services and fiscal responsibility. They have a reasonable expectation of value for money because they are responsible for the total range of services, and can therefore create substitutes for traditional inpatient services, and efficiently develop specialty services that have economies of scale (Hadley, 1996b).

A mental health authority can be created at a purchaser or provider level, or both. For example, in the Robert Wood Johnson Foundation Program on Chronic Mental Illness in the United States, there were local mental health authorities of each type involved (Goldman *et al.*, 1994). The so-called 'mental health boards' in Ohio are based in county government as quasi-public entities with no authority to provide any services directly. They are responsible for planning and purchasing services, including inpatient hospital care. Local mental health authorities in Texas are located in community mental health centers, which directly provide most mental health services, but may contract for certain specialized services. The newly formed Mental Health Corporation of Denver is a private, not-for-profit company given public responsibility to purchase and provide a mix of mental health and social support services (Goldman *et al.*, 1992).

We believe that the purchaser level is most important because such an authority could consolidate the funding streams, contract for services, and monitor efficiency and quality. The purchaser level also has the advantage of keeping many of the positive aspects of the internal market but permitting the coordination of services. Another advantage for the purchaser model is that over time a specialized, professional and sophisticated staff will emerge with particular skills and interests in serving the mentally ill population. The current lack of such a human resource currently is a major issue in the planning and management of mental health services in the UK. Furthermore, separating purchaser from provider would encourage competition, and would open the market to private as well as NHS trust providers.

If, however, the new entity were to be formed at the provider level, the new entity would consolidate funding, deliver services and manage the clinical system. This is critical for the care of the seriously mentally ill where the coordination of services and the management of resources, particularly inpatient and residential services, have substantial clinical and economic payoffs for the users and the system. Local mental health authorities at the purchaser and provider levels offer the potential for better coordination of services and a focus on responsibility and authority crucial to the development of public trust and accountability. All these are required for the implementation of community care for the seriously mentally ill.

## **A Model for the UK**

These new entities could be created at either the purchaser or provider level or, as they exist in a number of jurisdictions in the US, at both levels, where a single purchaser may

be responsible for multiple consolidated providers. This combination is now the emerging model for innovative services in the US. In the UK, the development of a local mental health authority at the purchaser and/or provider level might be relatively simple. Although the creation of a statutory authority would require primary legislation and is therefore probably not a short-term solution, there appears to be a variety of administrative options that would have the same effect.

## Purchaser Level

At the purchaser level, creation of such an authority could be achieved by administrative agreement to consolidate all the funding for the secondary and tertiary care of the mentally ill (Hadley, 1996b; Goldman *et al.*, 1992). This would move all the current mental health funding from social services, health authorities and GPs into a single purchaser most likely in the health authority.

This new purchaser could include representation by the three groups, be governed in various ways and produce many of the advantages of a local mental health authority with clear priorities and agendas. This mental health authority would be responsible for providing all mental health services, and for having a clear and publicly accountable mental health director. It could be governed by a board in a manner similar to its current governance with board members appointed by central government, elected locally or appointed by other local officials. It could also function within the NHS management structure in ways that are similar to the current pattern, and deliver many of the services to the mentally ill directly through a coordinated service system.

This model would require changes in both health and social service policy with regard to mental health services, but may be possible without new legislation. A single purchaser would then replace the current fragmented system of purchasing by health authorities, GPs and local authorities. It is interesting to note that this model has, in some form already, been partially attempted in the joint commissioning projects that have been locally developed around the UK. Although these projects are a step in the right direction, they often involve just a limited range of services for a defined cohort of clients which can further split the system.

## Provider Level

Another model is to consolidate services so the local community care trust becomes the local mental health authority at a provider level. In many ways, this would not require much change. The single provider model, for all practical purposes, exists now in some community care trusts or community mental health trusts. In most parts of the country, these trusts currently deliver most of the secondary and tertiary mental health care. Social service agencies are usually minor providers in the mental health care system, which are usually overwhelmed with other pressing concerns and priorities of other at-risk populations. In fact, most of the social workers responsible for the care

of the mentally ill work in joint health/social service settings. This new model would mean that both health and social services for the mentally ill would be managed and delivered by a single agency and that agency would be responsible to one or more purchasers for the efficiency, effectiveness and quality of its service system. (There is some lack of coterminosity but this has already been addressed through arrangements for joint planning and joint commissioning).

## System Benefits

What are the possible advantages of such structures for the management and delivery of mental health services? First, the special problems and unique nature of the delivery of mental services to the seriously mentally ill would be identified as a particular issue, thereby focusing interest and expertise. Second, it would reduce the fragmentation of services to a more manageable level, which would permit the system to focus its resources to those clients most in need of services. Third, it would increase the professional and clinical management of mental health services with more specialty clinicians and managers. Fourth, it creates a single point of accountability and responsibility which is solely lacking. Currently, every local care system problem can be blamed on multiple parties with no clear line of responsibility for creating a solution. There is not even a single place to which advocates and clients may focus their complaints and recommendations for change, nor can they hold responsible one single entity for their legitimate concerns. Finally, a mental health authority would provide purchasers with a clear point of ultimate responsibility. It can be held responsible; it can be monitored; it can be compared to other services with similar responsibilities and can be subject to performance based contracts.

## Summary

The creation of a local mental health authority may be a necessary first step towards the development of a coordinated and comprehensive system of care in the UK. It seems likely that there is currently more 'political' support for the development of a purchaser model but the development of a sophisticated purchaser is also likely to take considerable time and effort. Although not all of the structural and policy problems of the mental health system in the UK will be solved by local mental health authorities, it may be beneficial if responsibility for mental illness care is centralized and fragmentation is reduced through this system. Local developments such as joint purchasing and the coordination of health and social services may lead to some improvements, but the vast majority of areas will continue to struggle. Without making structural changes, the best efforts by clinicians, policymakers and managers are most likely to be in vain. Without a clear point of ultimate purchasing and service responsibility, the fragmentation and inefficiency of the current system will remain (Hadley *et al.*, 1996).

## Acknowledgement

The authors acknowledge the assistance and encouragement of Matt Muijen, M.D., and Geoff Shepard, Ph.D., of the Sainsbury Centre for Mental Health. Partial funding for this work was provided to the authors by the Sainsbury Centre for Mental Health, London.

## References

- Goldman H, Morrissey J, Ridgely MS. Evaluation of the Robert Wood Johnson foundation program on chronic mental illness. *Milbank Q.* 1994; **72**: 37–47.
- Goldman HH, Morrissey JP, Ridgely MS, Frank R, Newman S, Kennedy C. Lessons from the program on chronic mental illness. *Health Affairs* 1992; **11**: 51–68.
- Hadley TR. Splitting the difference. *Health Service J.* 1996a; **11**: 21.
- Hadley TR. Financing changes and their impact on the organization of the public mental health system. *Admin. Policy Mental Health* 1996b; **23**: 393–405.
- Hadley TR, Goldman H. Effect of recent health and social service policy reforms on Britain's mental health system. *Br. Med. J.* 1995; **311**.
- Hadley TR, Muijen M, Goldman H, Shepherd G. Mental health policy reform and its problems in the UK: déjà vu. *Current Opinion Psychiatry* 1996; **9**: 105–108.
- Han C. Population-centered and patient-focused purchasing: the UK experience. *Milbank Q.* 1996; **74**: 191–214.
- Kavanagh S, Knapp M. Market rationales, rationing, and rationality: Mental health care reform in the United Kingdom. *Health Affairs* 1995; **14**: No. 3.
- Mechanic D. The Americanization of the British National Health Service. *Health Affairs*, Summer 1995; 51–67.
- Muijen M. Heresy about the inquisitions. *Health Service J.* 1996; 29 February.
- Muijen M, Hadley TR. The incentives war. *Health Service J.* 1995; 9 March.