Lines in the sand
SUMMARY

A summary of findings from *"Crossing the Line"*: a research project on the interface between mental health and learning disability services

Funded by the South West Regional NHS Research and Development Directorate

Ken Simons[+]
Oliver Russell

Norah Fry Research Centre
University of Bristol
3 Priory Road,
Bristol BS8 1TX
Email: o.russell@bristol.ac.uk

Norah Fry
Research Centre

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[+] Ken Simons completed the final draft of this report before his death in January 2003.

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EXECUTIVE SUMMARY

The main objective of this research project, which was funded by the South West Regional NHS Research and Development Directorate, was to carry out an audit of 'pressure points' within services for people with learning disabilities and mental health needs in South West England. A retrospective two-year census of case files (n=348) was carried out, supplemented by in-depth interviews with key clinical staff (n=30), and semi-structured interviews with commissioners from *Valuing People* Partnership Boards (n =10) and Local Implementation Teams for the NSF for Mental Health (n=9). The main outcome measures were descriptions of patterns of service use, along with the presence (or otherwise) of disputes and/or joint working, set in the context of the views of providers and commissioners.

The results show that although there was some evidence of joint working at the local level, there also continue to be disputes between key agencies. To date *Valuing People* and the NSF for Mental Health appear to have been implemented in parallel rather than as co-ordinated strategies. Further, within specialist learning disabilities services there is evidence of:

- continued 'out of area' placements for a small number of individuals for whom there are no local services
- additional un-resourced pressures in relation to people who have been placed 'into area' in residential care
- bed blocking within in-patient services.

Concerns about the adequacy of social care for people with learning disabilities and mental health needs was an underlying theme.

There is a case for ensuring a much clearer linkage between the implementation of *Valuing People* and the NSF for Mental Health. Further, it will be critical to ensure that *Valuing People* housing and support strategies are genuinely comprehensive and reflect the full range of needs (including people with learning disabilities who have offended).

Start and end dates of the project

The project started on 1st September 1999, and was completed 31st August 2002.

Research team engaged on the project

- Ken Simons, lately Senior Research Fellow, University of Bristol.
- Oliver Russell, Honorary Research Fellow, University of Bristol.

The authors would like to acknowledge the additional assistance in collecting data from case files (along with comments on the final report) provided by Padraig Quinn and Dietmar Hank (Bath and North East Somerset PCT). Fiona Macaulay (Norah Fry Research Centre) assisted with the interviews with commissioners.

Section 1: Background to the audit

Aims and objectives

Concerns about the adequacy of services for people with learning disabilities who have additional mental health needs are widespread. Anecdotal evidence had suggested that in the South West Region there were significant problems with:

- confusion about the respective roles and responsibilities of mental health and learning disability services
- 'bed blocking' of in-patient assessment and treatment resources caused by (it is suggested) lack of social care facilities with the appropriate expertise
- the lack of local capacity, necessitating expensive 'out of area' placements
- unpredictable demands from individuals originating outside the Region.

The emergence of attempts to 'modernise' the mental health services through the implementation of the National Service Framework for Mental Health (Department of Health, 1999c) and *Valuing People* (Department of Health, 2001) provides a possible framework for starting to address some of these concerns. The main aims of the study were therefore to carry out a comprehensive audit of key pressure points, and to explore the findings in the context of changing policies for both learning disability and mental health services.

A summary of methods

The audit consisted of three interlinked stages:

Stage 1 of the research consisted of a retrospective two-year census of case records of adults with a dual diagnosis of learning disabilities and mental illness (aged 19 and over) covering the period 01/07/1998 to 30/06/2000. An extensive screening of case notes took place to identify individuals who fitted the following criteria:

- referrals between learning disability and mental health services (in both directions)
- placements 'out of area' by specialist health services, along with referrals to such services on behalf of individuals who had originated from elsewhere (referred to as 'into area'' placements)
- admissions to in-patient settings, either to dedicated learning disability assessment and treatment units or to mental health resources.

A semi-structured proforma was then used to capture data on an entirely anonymous basis.

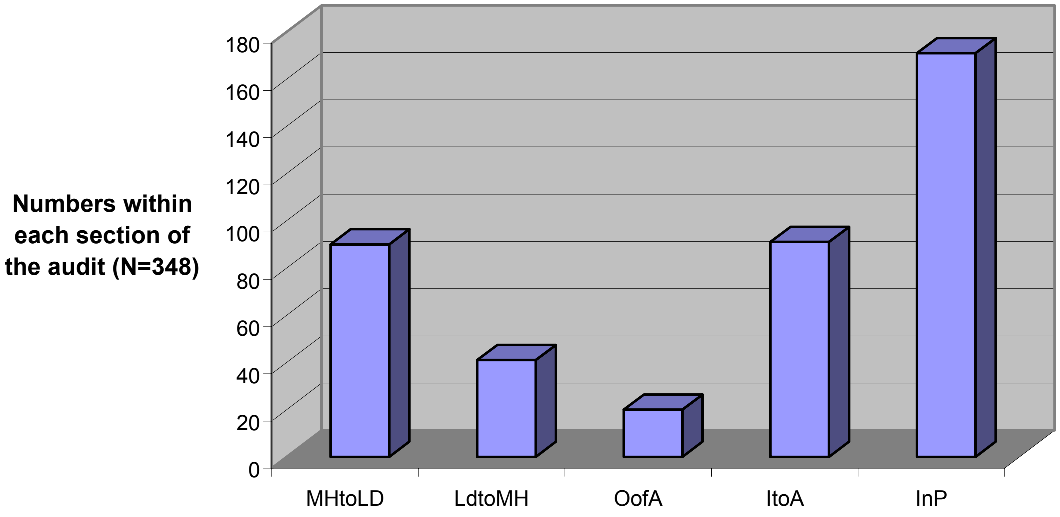
The census covered six different areas within the South West, representing approximately 60% of the regional population. Anonymity has also been extended to locations. Data was gathered on 348 individuals who had learning disabilities and mental health needs, an estimated 87% of those who met the criteria for inclusion.

For **Stage 2** a sample of cases from each area was drawn, and the anonymous details used as a basis for a series of in-depth interviews with 30 of the key actors in the local services. These included psychiatrists, psychologists, and community learning disability nurses.

Finally, in **Stage 3** a semi-structured questionnaire was used to conduct telephone interviews with 19 commissioners from across the region - 10 from learning disability Partnership Boards and nine from the local Mental Health National Services Framework Implementation Teams (the Local Implementation Teams or LITs). The aim of this exercise was both to provide a commissioner perspective, and to set the data from the earlier stages against standards from the relevant policy documents.

The chart below shows how many people fall into each sub-section.

Figure 1: Chart showing the numbers of people falling into each sub-section[1]



Section 2: Interchanges between learning disability and mental health services

This section focuses on the interaction between learning disability and mental health services. It describes the flows between the two services, looks at the way 'exchanges' are managed, and briefly explores areas of tension and dispute. Finally, the findings are set in the context of the views of providers.

Summary of data from case notes

The key points to emerge from the case note data include:

- The predominant flow is from mental health to learning disability services, rather than the other way around.
- Most referrals are accepted, but there continue to be disputes between the services. Issues associated with disputes included: disagreements about roles and responsibilities, and access to long-term placements.

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[1] Key for chart: MH to LD- Mental health to learning disability services, Ld to MH – Learning disability services to mental health, O of A – Out of area, I to A – Into area, InP – In patient services.

- ‘Exchanges’ of people between services are largely managed through the straightforward transfer of clinical responsibility or through the limited provision of advice or assessments of the individuals involved. Only 15% were judged to involve joint working.

The views of the providers

The interviews with the providers generally confirmed the picture derived from the analysis of case notes. The points made included:

- Most professionals in the learning disability services have links with colleagues in the corresponding mental health service, mostly in a professional development context (where they meet with their peers). However, joint service developments are rarely a feature of the agenda for these groupings.
- Most could point to examples of joint working. However, these are relatively limited (though perhaps less so from the perspective of nursing staff who were more likely to work across the boundaries) and often reflect positive personal relationships. Conversely, there are few structures or mechanisms to encourage and support joint working where such relationships are not established.
- Disputes about the relative roles of the two services continue to be a problem in most areas (though to varying degrees). However, the absence of disputes does not necessarily represent a meeting of minds. In many instances the arguments are sufficiently well rehearsed to limit attempts to refer individuals across service boundaries. As one clinician put it: ‘*Possession is nine-tenths of the law’*.
- Historically, learning disability services have often acted as a ‘back-stop service’ that would accept people who did not fit the remit for other services. Although this may no longer be the case, the perception lingers. The result is that individuals are still referred to learning disability services because they do not ‘fit’ elsewhere (and here the example of autism was mentioned). As one clinician observed: ‘*It still feels like a one-way street’.*
- As a result, many feel that services are still a long way from a position where ‘health facilitation’ (supporting individuals to access generic services) could be an effective role for specialists supporting people with a learning disability and mental health needs.
- There are continuing ‘cultural’ differences between learning disability and mental health services. The latter are perceived to be dominated by ‘rehabilitation’ and ‘treatment’ oriented approaches focused on trying to restore people to ‘normal functioning’ as soon as possible. In contrast, learning disability services are more geared around the need to organise effective long-term support for people. These cultural differences complicate working jointly, and result in ‘asymmetric’ assumptions about the appropriateness of services.
- Pressures on both services are well recognised (although there may well be differing perceptions of who is under the greatest pressure). The result is a defensive approach largely geared to coping with ‘*unmanageable’* levels of demand. The situation where individuals are ‘*batted’* backwards and forwards between services are acknowledged to be particularly unfortunate for the

individuals involved, but without some wider framework within which to operate there is a degree of inevitability about this.
- There was a general recognition that there are groups of individuals who fall on the edge of *both* services who, collectively, probably have more in common with each other than with the 'core' constituents of each service. Many in this group pose significant challenges for services, are difficult to engage with, and will often need very long-term support (in other words there are significant long-term cost implications of taking on responsibility for their care). These groups would be an obvious focus for *joint* initiatives.
- There was a strong sense from the providers that the NSF for mental health had passed learning disability services by: '*As far as the NSF is concerned there has been no impact really'.*

Strikingly, several of the providers interviewed used the same phrase. They reported that they had been to the meetings and at regular intervals had posed the question: *'And what about people with learning disabilities?'* Nevertheless, when critical decisions about future developments were being taken, the planning had focused exclusively around existing mental health services. Indeed, in several areas, early confusion about the scope of the NSF for mental health was reported. Although *Valuing People* had subsequently made it clear that people with learning disabilities who had mental health needs were to be included in the NSF for Mental Health, most providers felt this had not translated into practical changes, and reported little, if any, access to 'modernisation' money associated with the NSF.

Section 3: 'Out of area' and 'into area' placements

This section attempts to look at flows of people with learning disabilities and mental health needs in two opposing directions: those placed 'out of area', and those placed by other authorities into independent sector residential provision, who were subsequently referred to the local specialist learning disability service.

Summary of data from the case notes

The data from Stage 1 indicated that:

- There is a small (just 20 examples over the two years) but continuing flow of individuals 'out of area' (and mostly out of the Region), triggered by a combination of placement collapse, a lack of specialist provision, and in some instances, the very complex needs of the individuals. All but two of these individuals had been involved with either the criminal justice system or had been detained under the 1983 Mental Health Act.
- Referrals to specialist learning disability services on behalf of individuals placed 'into area' continue at a significant rate. (Two-thirds are from outside the South West Region).
- There are indications of questionable placement practice in relation to some individuals, with little evidence that their health needs are assessed prior to placement, or that where health needs were known to exist, that appropriate arrangements are put in place.
- Although most support was provided on an out-patient basis, 10% of those 'into area' placements were admitted to local in-patient resources.

- There was evidence of some kind of dispute arising between the local specialist health services providers and the placing agency for just over a third of the individuals included.
- There was a regrettable level of policy confusion about the interaction of health and social services commissioning responsibilities, compounded at a national level by a lack of clear guidance.

The views of providers

The 'out of area' moves reflect some of the classic dilemmas of low-volume high-cost services. The interviews with providers revealed:

- There was widespread concern that the lack of *local* specialist provision was continuing to lead to 'out of area' placements that might have been avoided. There was particular concern about the difficulties of accessing suitable forensic services (particularly for women), or settings where people needed to be detained under the 1983 Mental Health Act and accommodated in secure conditions over the medium to long term.
- Despite their high costs, many of the interviewees expressed doubts about the value and quality of the 'out of area' placements. These were compounded by the difficulties of monitoring such placements over long distances. There was concern that the resources may well be better deployed in developing local capacity. However, no comprehensive commissioning strategies had yet emerged.
- There was some concern that devolving commissioning to the level of Primary Care Trusts would be likely to compound the problem. Several interviewees argued that there was a need for active commissioning to be developed at several levels. The Regional Specialist Commissioning Group for forensic services had yet to report, but there was general support for the idea of *small* secure settings developed at a supra-district level, coupled with the active development of local community based forensic skills.

In contrast, discussion of the 'into area' placements raised a very different set of concerns:

- There was a widespread criticism of poor placement practice, leading to a lack of continuity in providing adequate care. Examples included failure to arrange appropriate Section 117 aftercare.
- The net inflow was seen as a major problem by most (although not quite all)[2] service providers. Their perception was that the additional workload was not reflected in the resourcing of services, leading to increased pressures and diluting their capacity to meet the needs of local people.
- The 'asymmetrical' policies relating to health and social care commissioning mean that *local* social services departments are not generally involved with the 'into area' placements, and in some instances appeared to be unaware of the scale of the flows into the locality. As a result, there is some concern that commissioning led by social services is unlikely to reflect the pressures involved.

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[2] In two instances there was a recognition that, at the very local level, in-migration was matched or exceeded by the local levels of out of area social care placements.

As one interviewee pointed out, in the more extreme instances, the local health and social services are planning for quite different populations.

- Situations where individuals move through a series of ‘out of area’ placements tend to weaken the commissioning links, creating substantial confusion about responsibilities.
- While there was recognition that some very good independent sector provision exists, there was also considerable concern about the willingness of some providers to ‘import’ individuals with complex needs without the capacity to provide effective support. Several interviewees expressed the concern that services which were not seen as competent by local purchasers were *more* likely to import people from elsewhere to make up for the ‘lost’ business.
- Although *Valuing People* emphasises the importance of developing local services and minimising the use of ‘out of area’ placements, there are concerns that the pressures that drive the net inflow into part of the region (the pushes of high costs in some part of the country, along with lack of specialist provision in those areas, coupled with the pull of an independent sector attracted by the low costs of rural areas) still exist.

Section 4: In-patient admissions

Within all of the areas included in the study services had the capacity to admit individuals for assessment and treatment[3], although they varied considerably in the numbers admitted and the type of resources used for this purpose. This section focuses on the circumstances of the 171 individuals considered for such an admission during the study period.

Summary of the data from the case notes

- In-patient admissions were occurring at a rate equivalent to three per 100,000 of the general population per year. However, this is more a reflection of supply than of demand.
- Most admissions were to specialist learning disability assessment and treatment units, with just 11% using general mental health beds.
- The length of stay was often considerable; for 40% it exceeded six months, while for 12% it was at least two years.
- Just under half of the individuals admitted, returned to their previous place of residence, with this proportion falling dramatically as the length of stay increases.
- Difficulties finding an appropriate alternative placement were noted for over half of those not returning to their previous placement, with the proportion rising as length of stay increases.
- The length of stay was the focus of a number of disputes between health and social services (though not always between local agencies). There was also some evidence of excessive lengths of stay having a negative impact on some individuals.
- Just under half of those admitted had previously used in-patient resources.

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[3] It is important to stress that *most* assessment and treatment will be carried out in community based settings.

The views of the providers

In-patient provision tends to be expensive. Not surprisingly, therefore, it also tends to be a focus of attention amongst providers:

- Widespread (though not universal) concern about ‘bed blocking’ of in-patient resources reflected two underlying (and related) sets of issues: the responsiveness of social services care management systems, and the difficulties of identifying providers capable of reliably supporting people with complex needs. There was also some self-criticism of the failure to develop ‘assertive’ discharge plans at the point of admission.
- There were concerns about the ‘perverse incentives’ that discourage social services departments from responding to instances of bed blocking. While some interviewees reported difficulties in engaging with care managers, others were positive about their relationships with front-line staff, arguing the problems lay at the level where funding decisions were made (funding ‘panels’ were cited as a problem in numerous instances). Clearly it is likely that social services departments would have a different perspective on these issues, as was acknowledged by some of the interviewees. It was recognised that social services departments were under considerable pressure; they have to prioritise the use of resources, and from their perspective social care crises in the community may well appear a more urgent priority than people who are ‘safely’ housed in in-patient settings. There was even a recognition in some instances that local social services departments perceived local health spending on learning disability services to be relatively low, and that slowness in responding was a way of prompting health to pick up their share of the bill. However, from the perspective of *providers,* being caught between these two pressures was uncomfortable, and many interviewees made the point that the effect was to increase the social exclusion of already vulnerable people. It is also important to add that concerns about disputes between local agencies, though common and strongly expressed, were not universal; in one area there was support for the local joint strategy to tackle the issue, and in another (where relationships had been very tense) there was some optimism that the situation was changing. However, for the majority of respondents, there was concern that the issues had not yet been addressed.
- Concerns existed about the capacity of local residential services. There was an acceptance that in-patient resources are being used as a ‘sticking-plaster solution’ to crises in long-term social care services. This is reflected at both ‘ends’ of the admissions process; in the collapse of residential placements leading to admission (augmented by a significant number of care homes that were then reluctant to take people back, or for whom a return would clearly be inappropriate) as well as the problems in finding appropriate move-on accommodation. While some interviewees acknowledged the contribution made by some local independent sector services, there were still seen to be significant gaps in provision in most areas. In addition, while most local services do attempt to support the development of providers, the capacity to work proactively to prevent admissions is still often limited, as is the capacity to develop very specialised individual housing and support options for people with the most complex needs. While examples of outreach and crisis

response capacity are emerging in some areas, these are still the exception rather than the rule.

- There were mixed views about the adequacy of local in-patient resources. While some interviewees were concerned about the sufficiency of in-patient provision, others felt the problem lay elsewhere; the way that such resources were used rather than the scale of provision was often seen to be a greater problem. There was some debate about the feasibility of managing without dedicated learning disability assessment and treatment resources, although in practice there was a general acceptance that *some* level of specialist provision may be sensible (although again, the key issue is how such resources are linked to a wider strategy).
- Many interviewees reported mixed experiences of using generic mental health beds for in-patient admissions and could point to examples of individuals for whom such an admission had been a positive experience. However, some also expressed concerns about the use of such provision. Often it was said to be hard to access such resources (even where agreements were in place), and when individuals were admitted, there were also said to be pressures to move them on very quickly (tolerance of bed blocking was very low). Several interviewees commented that the impression given was that people with learning disabilities were there 'under sufferance' rather than positively welcomed. Indeed, many nursing staff on such wards were said to feel themselves ill-equipped to respond to the needs of people with learning disabilities, and there were concerns about the tendency for nursing staff to interpret behaviour of people with this label as a function of their impairment rather than as an expression of a mental illness. As they are currently provided, acute psychiatric wards were generally seen as inappropriate for people with more significant levels of intellectual impairment. While there were some emerging examples of joint training for staff in such settings, so far they appear to be the exception rather than the rule.

Section 5: The commissioning context

This audit was undertaken during the early days of the implementation of *Valuing People,* and to some extent, the early days of implementing the NSF for Mental Health. Further, the extensive organisational restructuring that has happened in both learning disability and mental health commissioning structures over the past few years means that many individuals have only taken up their role relatively recently. This context provides an important backdrop to the key messages from the interviews with commissioners that are very briefly summarised below.

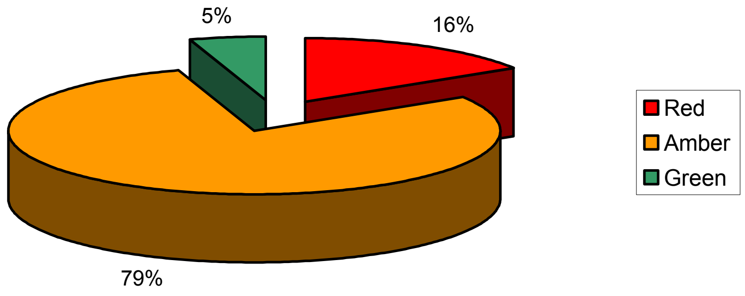
Key points:

- Some progress has been made (for example in developing housing strategies for people with learning disabilities), and further work has already been identified in key areas (for example, in developing agreed protocols for the relative responsibility of learning disability and mental health services).
- However, many commissioners acknowledged problems. For example, 14 out of 19 commissioners were aware of significant boundary disputes between mental health and learning disability providers, while conversely only three felt in-patient arrangements would meet the standards set out in the NSF and *Valuing People*.

- Unsurprisingly, when asked to rate the local situation in relation to the red, amber and green[4] ratings of the newly developed learning disability related performance indicator (that forms part of the self-assessment process of the NSF implementation teams) most said amber, with only one green and three reds (see chart below).
- Providers asked the same question were slightly more critical. However, the overall message from both providers and commissioners is clear: linkages between mental health and learning disability services are underdeveloped. If services are to live up to the aspirations of both *Valuing People* and the NSF, considerable efforts will be required.

Figures 2 and 3 show the responses in relation to the question on the performance indicators.

Figure 2: Learning disability performance indicator - views of commissioners only (N=19).



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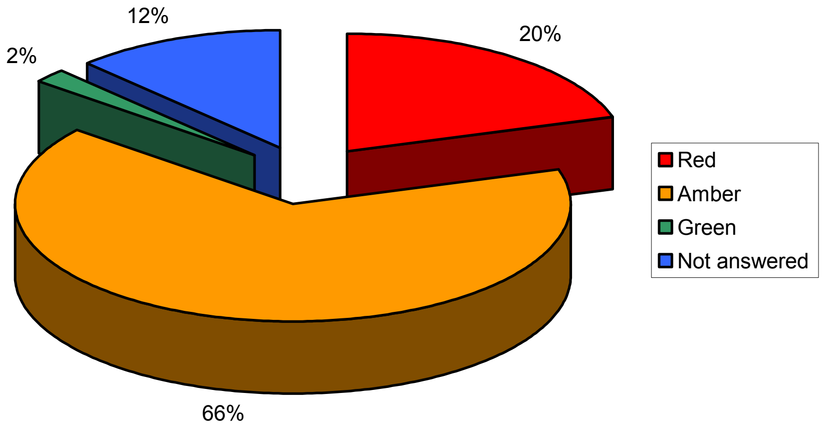
[4] 'Traffic light system' - red indicating that performance rating is poor, amber indicates that performance needs improving but there are some changes taking place and green, performance is good.

Figure 3: Learning disability performance indicator - views of commissioners and providers combined (N=49)



Section 6: Implications for health and social care

This audit suggests that there are continuing problems with ensuring that people with a combination of learning disabilities and mental health needs have access to a full range of effective services. This appears to be particularly true for those individuals who are on the ‘edge’ of eligibility criteria for the two key sets of specialist health services. The NSF for Mental Health and *Valuing People* agendas have the *potential* to make a significant contribution. However, so far it would appear that their impact has been relatively small, and there is a danger that they may continue to run in parallel rather than complementing and enhancing each other. Moreover, the difficult boundaries identified in the study were not just between learning disability and mental health services. The findings from the audit also act as a reminder, if one were needed, of the importance of effective links between the National Health Service and local authority services, especially housing and personal social services.

For this reason, the detailed implications for health and social care services can be grouped into the following two broad themes: managing the links between learning disability and mental health services, and developing comprehensive housing and support strategies.

Before moving onto the specifics, one important point needs to be noted: solutions to problems will have to reflect local circumstances. For example, in large population centres it may well make sense to develop a version of ‘assertive outreach’ within learning disability services. However, in some of the more rural settings, the development of more and more specialist functions will not be an option; there solutions will *have* to be more generic.

Managing the links between mental health and learning disability services

It would be possible to address some of the concerns outlined earlier by radically re-shaping specialist learning disability services. This is actively being considered in one area included in this study. However, while there is a case for tackling the issues through organisational restructuring, such approaches can only be part of the argument; there is always the risk that the boundary problems are moved rather than solved. The key issue, therefore, is how relationships across the organisation boundaries are organised. There is a case for Partnership Boards and Mental Health NSF Implementation Teams to develop a joint local strategy for promoting and supporting joint working. Options to consider for such a strategy include:

- developing agreed protocols for determining responsibility that both reflect the experiences of providers, and which value joint working; these specifically need to reflect the implications of the guidance on person centred planning (Department of Health 2002 a & 2002 b) and health action planning and health facilitation (Department of Health, 2002 c)
- building more substantive links between the two services at the local level, including greater use of mechanisms like joint appointments, joint membership of teams, or 'virtual' or 'meta' teams
- developing a programme of joint training, targeting both existing problem areas (for example ensuring that staff on acute psychiatric wards are better equipped to support people with learning disabilities), but also new areas of work (for example the implications of the new Mental Health Act)
- joint audit and research, targeted both at informing the strategy and identifying areas of joint interest
- carefully focused joint service developments reflecting those joint interests.

Some specific topics for consideration include:

- support for people with autistic spectrum disorders (particularly those who do not fit eligibility criteria for learning disability services)
- support for people with personality disorders with a borderline learning disability
- support for people with learning disabilities with dementia
- support for people with epilepsy
- reviewing the use of in-patient resources
- access to 'assertive outreach' and crisis response services
- access to development resources.

Some issues are probably sensibly tackled in consortia, rather than just at the local level. Options to consider here include:

- the development of local forensic options (preferably linked to the emerging recommendations of the Regional Specialist Commissioning Group)
- approaching the NHS workforce confederations in order to develop common training resources and curricula
- developing accessible health promotion materials that focus on mental health, particularly those that promote the capacity of individuals to give informed consent to treatment
- developing adapted materials for working with people with learning difficulties who have additional difficulties with alcohol or substance abuse.

Developing comprehensive housing and support strategies

One of the early tasks for Partnership Boards is to develop comprehensive housing strategies. As noted earlier, many of the problems identified within the audit reflected conflict about where individuals live (both in the short and longer term), and how they are supported. For this reason, genuinely comprehensive strategies will have to include consideration of:

- developing a full range of *local* options, including resources for people who are currently placed 'out of area' such as better links to forensic services and options for the very small number of people who require long-term treatment subject to the 1983 Mental Health Act
- consolidating existing health *and* social care expenditure on 'out of area' placements into a budget to be used for the active commissioning of local options for this group including reasonable assessment of future spending on 'low volume high cost' options
- a range of activities designed to develop the capacity of the local independent sector to respond to people with learning disability - and mental health needs; this may need to include 'market management' strategies designed to establish or attract new providers
- ensuring a capacity to design and develop very intensive individualised options for people with complex needs
- developing a strategy for preventing unnecessary in-patient admissions from independent sector housing and support services including the capacity to deploy resources very flexibly to provide additional support to individuals going through a crisis
- an agreed strategy for the prevention of bed blocking in assessment and treatment services; this is likely to be become a significant issue if the government extends its plans for cross charging for delayed discharge to people with mental health needs
- the development of effective 'low support' housing options with good links to both mental health and learning disability specialist health services, as part of a preventative strategy
- developing a consistent and assertive approach to 'into-area' placements.

The issue of 'into area' placements cannot be dealt with purely at a local level, it requires a much more consistent and coherent approach at a national level (possibly co-ordinated through the *Valuing People* Support Team). Options include:

- pressing the Department of Health to confirm the original 1999 draft *Establishing Responsible Commissioner* guidance (Department of Health 1999a), preferably updated in the light of *Valuing People*
- developing clearer expectations about good placement practice (for example, ensuring that people being placed 'out of area' have comprehensive health assessments prior to the move)
- working with the National Care Standards Commission to ensure that people placed 'out of area' are a priority for monitoring in the context of the National Care Home Standards; particular care needs to be taken that adequate care plans are being developed for people with more complex needs prior to

placement, and that care homes can demonstrate a capacity to meet the needs of people with learning disabilities and mental health needs
- clarifying expectations of care managers when individuals are placed 'out of area'
- exploring the possibility of resource adjustments to reflect the increased pressures that already exist due to historical placement practices (possibly through extending the resource adjustments to Primary Care Trusts through the Out of Area Treatment System - Department of Health 1999b).

In turn, local services would need to respond to what would hopefully represent a changed environment. This would include:
- ensuring any 'out of area' placements' made from the local area also reflect ideas about good practice and continuity of care
- being clear with independent sector providers about the expectations of them including notifying local services at the point that people move into the area, and forwarding health assessments so that adequate arrangements can be made
- ensuring service level agreements with placing authorities are in place where appropriate
- ensuring that the complexities of inter-agency relationships do not prevent treatment being provided on the basis of clinical priorities.

Dissemination

Key findings from this audit have been presented to two conferences in the Region, the second involving representatives from both Partnership Boards and the local Implementation Groups for the Mental Health NSF. Points made at both events have been incorporated into the section on implications of the study. Further dissemination is planned as follows:
- This summary will be placed on the Norah Fry Research Centre website and will be available free from the Centre (see below)
- Discussions are planned with both the *Valuing People* Support Team, and contacts in the South West from the National Institute of Mental Health for England (NIMHE) in relation to developing some practical material for Partnership Boards and LITs (a checklist has been suggested) on the basis of this material.
- Opportunities will be sought to produce the early publication of an article targeted at the Mental Health NSF Local Implementation Groups involved in the self-assessment exercise.
- A series of three linked articles will be produced for a peer reviewed journal.

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FULL VERSION OF THE REPORT

A full version of this report (128 pages including appendices) is available from the Norah Fry Research Centre for £8.00 (including postage and packing). Please contact Marilyn Baker at Norah Fry Research Centre, University of Bristol, 3 Priory Road, Bristol, BS8 1TX to order a copy. Email m.baker@bristol.ac.uk; Telephone 0117 923 8137