



Implementing mental health policy: learning from previous strategies

A review of literature, interviews and focus groups to explore what helps and what hinders the implementation of mental health policies

Executive summary

This report for the Mental Health Taskforce explores what helps and what hinders the implementation of policies and strategies relating to mental health in England. We reviewed literature and carried out interviews and focus groups with people who have been responsible for policy implementation over the last 20 years. Following this, we identified 12 factors that influence the implementation, as intended, of strategies. They are:

- 1. Money:** strategies supported with extra funding have a greater chance of success, with funding for the process of change and the associated double running costs being particularly important.
- 2. Focus:** strategies with a clear narrative and a small number of widely supported action points are more likely to succeed.
- 3. Targets:** mainstream health policy continues to be driven, at least partly, by targets and incentives, and mental health strategies have benefited from close alignment with these, and struggled where they are not.
- 4. Scrutiny:** visible accountability for achieving a strategy's goals is essential to sustain implementation after early enthusiasm, both nationally and locally.
- 5. Passion and public opinion:** strategies that enjoy support from the public and professionals, that resonate with people's values and aspirations, are more likely to be implemented well.
- 6. Leadership:** effective national and local leadership is vital for success. Collaborative leadership styles are likely to be more conducive to mental health policy implementation that requires multi-agency cooperation.
- 7. An engaged workforce:** the most important changes are often the least amenable to policy-making and depend on the motivation of staff, while workforce planning and development are essential to translate ideas into practice.
- 8. Partnerships:** locally and nationally, mental health policy relies on organisations working together, but this often means working against the grain of public sector systems, business processes and incentives.
- 9. Implementation support:** robust, stable and supportive implementation infrastructure is vital to help local areas to translate policy into achievable actions, and to facilitate learning from one locality to another.
- 10. Innovation, evaluation and adaptation:** policy cannot stand still; it needs to enable innovation, to learn from its successes and failures, and to adapt to changing circumstances.
- 11. Management:** good quality project management is essential for local areas to implement change.
- 12. Time:** changing practice takes longer than policy-makers think. Policies need time to get implemented effectively; and investing in time to get processes right is crucial for success.

Recommendations for the Taskforce

Based on the evidence gathered in this review, we recommend:

1. The Government and the NHS should ensure that sufficient funding is made available to achieve the Taskforce's recommendations. Investment is needed to support the processes of change, such as protected time for learning, project management and local leadership, and the double running costs associated with reinvestment.
2. The Arms' Length Bodies¹ should jointly invest in a robust and stable implementation support system for the Taskforce recommendations. This should be sustained for sufficient time to provide a wide range of commissioners and providers of mental health support with ongoing help, advice, training and development.
3. The Taskforce and Arms' Length Bodies should consider how local leaders and partnership and management arrangements will be identified and supported to implement the report's recommendations. These will be crucial catalysts of change in localities, and they will need to be mirrored nationally to support and encourage ongoing action.
4. The Arms' Length Bodies should ensure mental health is given equal prominence in all new and existing policy implementation mechanisms, including in all aspects of the implementation of the Five Year Forward View, to avoid falling back into the margins of the system.
5. The Taskforce report should draw on the values, aspirations and expectations of people with mental health problems and of professionals. It should focus on a manageable set of actions that will bring people together, setting out clear expectations but without rigidly limiting how they are interpreted locally.
6. The Taskforce should stipulate what outcomes it wants to see and be clear how these will be measured. Measurable outcomes are crucial, but they need not be in the form of 'outcome measures' if process or input measures are likely to be more effective in holding national and local bodies to account for achieving agreed goals within agreed timescales.
7. NHS England should put in place robust, real-time evaluation mechanisms for the implementation of the Taskforce report. Evaluation is essential to identify what is working well, where difficulties are encountered, and how the strategy might need to be adapted on the basis of emerging evidence.

¹ The national Arms' Length Bodies set up by the Department of Health to implement health policy include NHS England, Public Health England, Health Education England, the Care Quality Commission, NHS Improvement (which replaces Monitor and the Trust Development Authority) and the National Institute for Health and Care Excellence.

Introduction and Methodology

The Mental Health Taskforce is producing a five-year plan for improved mental health support in and around the NHS. The plan will be the latest of many documents that have aimed to set policy and support its implementation in this field. This review of previous strategies was commissioned by NHS England from Centre for Mental Health and fed into the Taskforce's planning in 2015.

To help to ensure that this report makes as much impact as possible, we have examined what we can learn from previous strategies: looking at what has helped to make them successful and what has held back implementation. We have explored what are the core components of strategies that get implemented, and what we can learn from those that have had less impact and those that generated unintended consequences.

We carried out:

- A brief literature review of previous strategies and their implementation: focusing on how much impact they have made and what has been documented about why. A full list of publications reviewed is provided in the references section of this report.
- Interviews and focus groups with people in key roles supporting the implementation of strategy and the use of resources in mental health care, understanding their perspectives on what makes for success or failure.

In total we spoke with 18 people who have had key roles in the development, delivery and implementation of mental health strategies over the past 20-30 years. In three focus groups and four one-to-one interviews we asked participants:

1. Which mental health policies and strategies have been regarded as 'successful' in implementation? Which have been seen as largely unsuccessful? Are some regarded as 'good in parts'?
2. Are there any common factors in strategies that have been shown to be successful either in full or in part?
3. What evidence is there of what helps to implement strategies in practice? What has helped in the past:

- During the development of the strategy;
 - In communicating the strategy;
 - In supporting local implementation;
 - In holding systems to account?
4. What evidence is there of what hinders implementation? What has prevented all or part of previous strategies from getting implemented?
 5. What evidence is there about how and why strategies have unintended (positive or negative) consequences? What can be done to avoid unhelpful side-effects?

Based on the literature review and interviews, we identified key themes relating to the implementation of previous strategies and policies. This report sets out the evidence about these themes, drawing upon specific examples from the last 20 years of mental health policy and its implementation.

This study has been limited by the lack of published evaluations of most mental health strategies during the last 20-30 years and by the number of people we were able to engage in focus groups and interviews during the time available.

Previous mental health strategies and policies

This review took as its chronological starting point the National Service Framework for Adult Mental Health Services (NSF-MH) in England, published in 1999. While the NSF-MH was preceded by very significant changes to mental health care in England (most notably the deinstitutionalisation process of previous decades), it was the first strategy of its kind and it has been followed by numerous other policies and strategies.

The most significant strategies and policies for this review are:

- **1999** *National Service Framework for Adult Mental Health Services*
- **2000** *The NHS Plan*
- **2004** *National Service Framework for Children, Young People and Maternity Services*
- **2005** *Delivering Race Equality*
- **2007** *Improving Access to Psychological Therapies (IAPT)*
- **2009** *The Bradley Report*
- **2011** *No Health Without Mental Health*
- **2014** *Crisis Care Concordat*

Few of the strategies that were discussed in the focus groups and interviews have been subject to formal evaluations. The NSF-MH and Delivering Race Equality had published evaluation reports (in 2004 and 2009 respectively) but in each case they explored what had been achieved to date, not how and why progress had been made and what had impeded implementation. More recent strategies, such as the Crisis Care Concordat, have had less time to be evaluated but may produce useful findings once more time has elapsed.

National Service Framework for Adult Mental Health Services

The NSF-MH is widely seen as having been highly successful, at least in part and at least for a period of time. In his 2004 review of the first five years of the NSF-MH, the then national clinical director for mental health, Professor Louis Appleby, noted that the document had a clear, powerful message:

“Its message was: wherever you live, this is the kind of service you can expect to receive; wherever

you work, this is the kind of services you should aim to deliver” (Appleby 2004, p66).

Implementation of the nine standards in the NSF-MH is widely acknowledged to be variable. The standards relating to secondary mental health services are universally recognised as having transformed the support people receive, particularly following the introduction of the new community teams that were specified a year later in The NHS Plan. It is notable, however, that many of those teams were subsequently withdrawn or scaled-back – that the benefits of the NSF-MH were not sustained in full.

It was also acknowledged, both at the time and subsequently, that not all of the considerable investment that was put into the NSF-MH was spent in ways the Government intended:

“Some of the money that has reached front-line services has been spent on the wrong things. It has been used to shore up the old services that the NSF and NHS Plan were intended to change... It has been swallowed up by historical deficits in a local health economy, whether or not these can be traced to mental health services” (Appleby 2004, p69).

National Service Framework for Children, Young People and Maternity Services

Standard 9 of the NSF for Children related to mental health services. It was regarded in our focus groups as having been markedly less successful than the NSF-MH. Despite having a national support team in place, it did not come with additional funding for local areas and the mental health elements were not regarded as a high priority within the framework as a whole. When government support faded, there was no local leadership in place to ensure momentum was maintained, and the profile of mental health within children’s health remained low.

Delivering Race Equality

The Delivering Race Equality (DRE) strategy was published following the Inquiry into the Death of David ‘Rocky’ Bennett at a psychiatric hospital in 1998.

In a foreword to the evaluation report for the strategy, Lord Adebawale noted:

“DRE was an ambitious undertaking, and it led to a number of groundbreaking and innovative ways of working. For example, the idea of focused implementation sites was a good one – as they provided an opportunity to test out the ideas and imperatives of the programme in a coordinated and comprehensive way... It is important that the legacy and the aim of what DRE set out to do continues to be progressed through clear and visible linkage with new policy and guidance” (Wilson 2009, p3).

Evidence of the impact of the strategy is very limited, however, and with 78 action points the report notes that it faced some major obstacles:

“The scope of DRE’s challenge was huge and expectations were very high – perhaps we could never have lived up to all of them... Different stakeholders including users, carers and professionals, had different interpretations about what DRE should be doing and how we should be doing it” (Wilson 2009, p7).

Improving Access to Psychological Therapies

The IAPT programme began in 2007 for adults with common mental health problems and was extended to children and young people (CYP-IAPT) in 2010. The IAPT programme is generally regarded as a successful ‘command and control’ initiative, led from the top down and achieving results quickly. Implementation of IAPT is ongoing and there were mixed views in focus groups and interviews about its effectiveness to date and its future sustainability.

The Bradley Report

The Bradley Report was a government-commissioned review of the treatment of people with mental health problems or learning disabilities in the criminal justice system. It prompted a major development programme that continues to this day. The report was viewed in focus groups and interviews as being successful, at least in part. This is also the verdict of a Centre for Mental Health review five years after its publication (Durcan et al., 2014), which pointed to the national roll-out of liaison and diversion services as a major achievement but which noted that many other recommendations have seen little progress since 2009.

No Health Without Mental Health

The Coalition Government’s strategy for mental health was published in February 2011 and followed a year later by an implementation framework. There has been no formal evaluation of the impact of the strategy so far but the views of focus group participants were largely negative. It was regarded as lacking any means of implementation and failing to reach beyond the converted in its appeal. Some participants, however, noted that the far-reaching idea of ‘parity of esteem’ for mental health was first mooted in No Health Without Mental Health and that without it many subsequent developments – such as the creation of waiting time standards for mental health treatment – may not have been possible. And others noted that specific areas of the strategy, such as the shift towards a recovery focus in mental health services, were implemented through a combination of local initiative and national support.

Crisis Care Concordat

The Crisis Care Concordat is a more recent policy but one which received widespread praise in our focus groups and interviews. It is regarded as having made a significant impact in a short time, bringing together national ambition and local action in a way that has not been seen since the NSF-MH.

Critical success factors

In this section, we look at the factors that have helped or hindered the implementation of mental health policies and strategies. We have grouped them under twelve headings, but they are inevitably interlinked and inter-dependent.

1. Money

The issue of funding was widely discussed in interviews and focus groups. There is a clear acknowledgement that we live in difficult financial circumstances. But the importance of funding to achieve change was recognised in the literature and focus groups.

The NSF-MH, for example, was implemented with the help of £1 billion of dedicated expenditure in its first five years and during a decade of unprecedented extra spending on health care in England. It was described in focus groups as being built on a ‘tide of money’ that made it much easier to create new services without having to close down existing provision. No Health Without Mental Health, by contrast, came with no extra funding.

Reviewing previous transformation programmes, including the NSF-MH and the closure of the asylums, the Health Foundation and The King’s Fund (2015) recently argued that all successful programmes have come with some extra funding to help systems make change.

The importance of funding for ‘double running’ is widely acknowledged as vital in mental health services, where investment in new or different services is required alongside existing services:

“A key lesson from mental health transformation is the need to provide double running costs, taking into account the time and capacity required to establish new services while maintaining but gradually reducing provision of old services.”
(Health Foundation and The King’s Fund 2015, 17)

Alongside double running costs, the importance of ‘investing in the process’ was mentioned frequently both in literature and focus groups. Staff training and development, project management, putting in place data collection processes, and the time required of leaders to develop local plans and strategies – particularly when working across organisational boundaries – can be costly and strain the capacity of local systems. Money is also required

for ‘implementation infrastructure’, a topic covered later in this report.

Focus group participants also raised the importance of getting the best value for money from the system and the value of economic analysis to identify where it could be better spent. Implementation of the NSF-MH has been criticised for creating new services without reforming those they were designed to replace. There appears to be some variation in this picture: some focus group participants described examples of NSF services being funded from savings made by closing inpatient beds, while others spoke of new services being set up in addition to existing ones, leaving them vulnerable to funding cuts as the new money dried up at the end of the decade.

Another criticism of the NSF-MH’s use of funding is that money was allocated through existing mechanisms, which reduced transparency and made it difficult to identify whether new services were producing savings or not (Health Foundation and The King’s Fund 2015). Even by 2004, it was noted that while spending on NSF-mandated community teams was rising, spending on secure services was rising by a larger sum, and it was even unclear how much of the money had actually been used for mental health care:

“Many...PCTs, faced with their own financial pressures, have not given sufficient priority to mental health care in comparison to other priorities such as access targets and waiting lists. In a devolved system of commissioning, there is very little earmarking of money allocated and spending on mental health has been left to local organisations to argue over.” (Appleby 2004, 69)

Focus group participants were clear that disinvestment is vital for any future strategy. But it is widely acknowledged that in previous strategies, projected ‘savings’ that could be made from more efficient or effective services have been over-estimated, for example in relation to the closure of the asylums and more recently to IAPT.

Focus group participants also felt that gaining (and keeping) the support and interest of the Treasury had been important for several previous strategies – most notably IAPT and The Bradley Report. The Treasury’s investment in these strategies was felt to be important in sustaining them beyond the initial enthusiasm and protecting them from budget cuts

over time.

At the local level, meanwhile, it has been noted that current financial systems tend to deter investments that are likely to benefit other agencies' budgets or whose financial benefits will not be felt for some time to come:

"It is extremely difficult to raise finance for transformation spanning commissioners and different types of providers... organisations are expected to develop a business case, demonstrate how the investment will lead to increased revenues or cost reductions, and repay the investment as those benefits are achieved." (Health Foundation and The King's Fund 2015, 6)

Even with a strong financial case for reinvestment, local decision-makers (commissioner and provider alike) may continue to have considerable disincentives to change where this will go against their organisations' interests and put them at a disadvantage relative to others. It will be important for the Taskforce to recognise the barriers to reinvestment and look at ways this can be supported both locally and nationally.

Reinvestment is achievable in certain circumstances, however. One focus group participant described how the current criminal justice system personality disorder strategy has, in recent years, managed to reinvest money previously spent on 'dangerous and severe personality disorder' services that were shown to be offering poor value for money. In this case, reinvestment was relatively straightforward to achieve through a single commissioner (NHS England), a small number of providers and clear evidence of the benefits. Reinvestment from secure mental health services, however, has been much harder to achieve with a more complex set of commissioners and providers despite similar concerns about the inefficient use of large sums of public money.

2. Focus

A criticism levelled at several policies and strategies has been their lack of focus: a tendency to cover too much ground with too many recommendations. Delivering Race Equality, for example, had 78 action points, and The Bradley Report contained 81 recommendations. The evaluation of DRE (Wilson, 2009) noted that:

"The DRE action plan aimed to improve mental health services for all people of minority ethnic

status in England... The definition included a wide range of groups with very diverse needs... Meeting the needs of all of these groups was always going to be a challenge" (p6).

The NSF-MH had nine standards but many were quite broad and included a range of requirements. Lawton-Smith and McCulloch (2013) argued that this undermined implementation of standards not included in The NHS Plan the following year:

"There was no clear hierarchy of priorities, giving the impression that policy is unachievable as a whole."

An international review of mental health policy implementation identified the province of Ontario, in Canada, as an example of a very different approach:

"Ontario has a ten-year combined strategy for mental health and addiction... The strategy is owned jointly by six ministries in the province and the reporting goes back to the highest ministerial group in the provincial government... They have... started with one or two areas with an aim to push change and improvements system-wide through improvements in these areas first... The focus is in improving services for children and youths in the first three years. This has entailed increased funding, which is meant to continue." (Gullers Group 2014, 22)

The review also looked at successive mental health strategies in Australia, and their diminishing impact over time. It found this reduction to relate to a combination of a lack of funding and a diminution of focus with each successive plan:

"Australia has had mental health plans since 1992...the additional funding that had followed the first national plan was discontinued in 1996. This is believed to be one of the reasons why the plans' impact over time has lessened. There is a sense that reforms only get done when there are funding signals..." (p10)

The fourth national plan, meanwhile, since 2009, "has not had the same impact as the earlier plans. The main cause seems to be that the plan, in an attempt to satisfy everybody's needs and desires, has ended up not really satisfying anybody's... it became difficult for the government to sort among all the strong voices and to see what the needs really were, so over time the reform got diluted in an attempt to do too much for too many." (Gullers Group 2014, 10)

The importance of focus and clarity can increase over time as the purpose of a policy gets forgotten. One focus group discussed the Care Programme Approach, introduced in the early 1990s as a way of meeting mental health service users' needs more holistically and in partnership. They described CPA as a good, simple idea that when done well makes a significant impact and that could be highly supportive of recovery. But it became the answer to everything and got bureaucratic, even being used for community care assessments: "a great idea that spiralled out of control". Without a clear sense of purpose, and no 'organisational memory' to hold onto it, the benefits of CPA have to some extent been forgotten and it has become a box-ticking exercise in many places.

3. Targets

The topic of targets in relation to health and mental health policy is highly controversial.

The NSF-MH is widely lauded for its clear, measurable (and subsequently measured) targets. The targets set for implementation of the NSF were included not in the original document, however, but in The NHS Plan a year later. Of the nine targets in the Plan, three were delivered by national bodies and six by local organisations (through partnerships known as Local Implementation Teams). Five years on, Appleby (2004) was able to report that all three of the centrally delivered targets had been achieved and the six local ones were on all track. All were what are now described as 'process' or 'input' targets, rather than measures of 'outcomes'. This was supported in focus groups as a way of measuring the processes that are known (or at the time, thought) to be associated with good outcomes.

It has been pointed out, however, that the downside of this approach was that NSF standards not given NHS Plan targets, for example in relation to mental health promotion and to primary care, made much less progress. And many of the new services that were mandated through targets were subsequently withdrawn or eroded once the requirement to put them in place went away. This implies that while targets can be beneficial, in the short-term at least, they can lead to an excessive focus on the areas targeted and if they don't win 'hearts and minds' the long-term result can be less impressive.

The relationship between the NSF-MH and The NHS Plan appears to have been crucial to their shared success in the mental health sector. Without the

NSF-MH, the NHS Plan would have had little to say about mental health; but without the NHS Plan, little of what was in the NSF-MH would have been delivered on the ground.

This symbiotic relationship between mental health and the wider health policy environment could be equally important for the Taskforce and the Five Year Forward View. Focus group participants were clear that mental health needs both to connect with mainstream health policy but at the same time to have space of its own.

Strategies since the NHS Plan have relied to a lesser extent on targets and incentives to meet them. But as The King's Fund notes, while the drift of current health policy is towards localism and away from performance management, there remains a substantial element of the latter in the system:

"Looking at the [Coalition] government's policies implemented so far, it is possible to detect an intention to shift away from central control to localism, and from performance management to a greater role for competition and transparency. However, as with previous governments, these policies are layered on top of previous policies. The implication is that performance improvement will be driven through a variety of levers and incentives for the foreseeable future." (Gregory et al., 2012, 61)

Focus group participants strongly advocated the need for a small number of measurable targets from the Taskforce that will be included in mainstream accountability frameworks across the system.

4. Scrutiny

The impact of targets is dependent on commitment of the system and its leaders to measure achievement against them and hold themselves accountable for how well they do. Without scrutiny and accountability, measurement has little value. An assessment of the Coalition Government's health policies (Gregory et al., 2012) concluded that measurement of outcomes is not in itself enough to bring about change:

"The focus on outcomes...[is] founded on a belief that transparency will, in and of itself, drive improvements. There is some evidence that publishing comparative reports can impact on the performance of organisations – particularly poor-performing ones...but there is also evidence that simply publishing data is not enough." (p59)

The NSF-MH provided regular progress reports on the achievement of targets in the public domain. Local implementation teams created a forum through which the agencies that were accountable for delivering on the NSF could assess progress and find ways to fill gaps.

No Health Without Mental Health, by contrast, 'started with an impressive hurrah' but had 'no measurements and no actions' (focus group participant). At the same time, however, the IAPT programme was collecting regular data from local services (as a requirement for being part of the programme) and these were presented each month to the Prime Minister to keep track of progress.

The Crisis Care Concordat's approach to scrutiny includes the use of published maps to identify areas making progress with their declarations and action plans (and by definition those who are falling behind, giving local Healthwatch and Mind organisations a platform to push for more). A 'thank you letter' from the minister of state was also sent to areas producing their declarations: a reminder that scrutiny can take a positive, reinforcing approach as well as simply being about dealing with poor performance. And both locally and nationally, extensive media coverage was sought for initiatives being undertaken, underlining the positive nature of the process but also generating a sense of expectation that declarations will be followed by action.

Accountability for implementing The Bradley Report, meanwhile, was greatly enhanced by the role of the Women's Institute, which at the time the report was produced had begun a campaign on criminal justice and mental health based on the experiences of one of its members. The WI got behind the report, and both nationally and locally has held decision-makers to account for making progress on liaison and diversion. Its reach and influence at the top of government has helped to keep an issue on the agenda that could easily have fallen by the wayside.

It is clear from several strategies, however, that scrutiny has to be sustained. Whereas crisis resolution teams were once the subject of detailed scrutiny under the NSF-MH and NHS Plan, it now 'takes an investigative journalist to find out' what is provided where for people in a crisis (focus group participant). The experience of the Delivering Race Equality programme is also a reminder that measuring changes that can only happen long-term (e.g. the disproportionate use of inpatient care for people from BME communities) is both a poor

measure of activity in the short-term and, if not sustained beyond the five years of the programme, its longer-term impact is limited.

5. Passion and public opinion

A common feature of strategies that have been successful, wholly or in part, is that they enjoy strong and passionate support from the outset. Rather than trying to create enthusiasm, they are able to tap into the 'zeitgeist' and draw on the energy of people in the system. Disruptive change to routine practices needs to be perceived as necessary and as common sense to give people permission to be more innovative: a belief that 'we can't carry on like this' coupled with 'visibility, undeniability and a body of evidence' (focus group participant).

Successful strategies are able to connect with changes in public opinion, values and expectations. They say what people are already thinking about mental health and about what our society should be like:

"...public opinion was influential in the impetus for transformation in both mental health case studies: deinstitutionalisation emerged as a result of shifting social attitudes towards detention in large asylums, while the NSF-MH was developed as a direct result of issues raised by the public and media in relation to public safety." (Health Foundation and The King's Fund 2015, 14)

"It is important to have an honest, powerful, well communicated narrative that goes beyond technical and clinical issues. This is more likely to succeed where there are ethical and emotional arguments shared with key stakeholder groups and where those groups are engaged with the change process." (Gilbert 2014, p1)

The development of Early Intervention in Psychosis (EIP) services illustrates the value of a small number of 'messianic practitioners' (focus group participant) and families who were able to present as a necessity the idea of creating new services that, at the time, had no evidence base. They were able to articulate the ethical case for change, tapping into people's experiences and frustrations, gaining support from voluntary sector organisations and, over time, government officials. Early Intervention in Psychosis simply seemed like common sense and united clinicians, service users and families behind it.

The Crisis Care Concordat was first instigated

by leaders of the twenty two national signatory organisations who were brought together by the Minister of State to agree commitments and sign up to national actions. The first locality-based Declaration and action plan was published soon afterwards following frustration expressed by a group of GPs in one local area, who were concerned about their patients' experiences of gaining access to urgent help when this was needed. This approach then spread nationally.

Before publishing the Concordat, leaders of the national signatory organisations were brought together by the minister of state to agree and sign up to their actions. Many had personal experiences they were able to draw upon about the unacceptability of the current position and the necessity of change. This helped to motivate them to work together and agree a shared agenda that they each supported with their networks to encourage local implementation. In many local areas, similar processes occurred, sometimes pushed along by local media coverage of poor practice that motivated local organisations to work together rather than blame one another and shift responsibility.

The role of evidence in promoting mental health policy implementation, meanwhile, is less clear. As the example of EIP indicates, and subsequently the creation of community treatment orders (CTOs) and more recently street triage, change doesn't always require an evidence base to be implemented widely. It is also clear that well-evidenced policies and interventions do not necessarily succeed. Focus group participants argued that evidence alone will not drive change, but where it coheres with people's experiences, beliefs and aspirations, it can help to support the process. And where there are gaps in the evidence base, as with the NSF-MH, expert opinion (from those acknowledged to hold it) has been used as the closest available alternative.

6. Leadership

Effective leadership appears to be critical to every successful strategy, locally and nationally.

National leadership is necessary both to give rise to the strategy and to sustain its momentum and profile during implementation. Lord Bradley and the WI in relation to the Bradley Report, Norman Lamb in relation to the Crisis Care Concordat and Louis Appleby in relation to the NSF-MH were all crucial to keep driving change and to offer a figurehead for the process of implementation well beyond the

initial phase. They provided a consistent, persuasive narrative and persistently demanded attention to the strategy.

Focus group participants were clear that national leadership – and accountability – for implementation is crucial. One noted that while 'taskforces burn out', ongoing leadership is essential to sustain energy levels beyond the publication of the strategy, where in the past they have quickly dissipated at this point. Participants said someone in a position of authority would need to "put their reputation on the line in a convincing way" in support of the strategy and ensure that it aligned with messaging from the centre, with payment systems and with mainstream accountability mechanisms for national and local organisations. Such leadership becomes more, not less, important over time to help the strategy to adapt to changing political or economic circumstances and to emerging evidence and ideas.

Local leadership is of equal, if not greater, importance. Reviewing evidence on what helps and hinders local improvements to primary care mental health support, the London Mental Health Strategic Clinical Network (SCN) (2014) concluded that:

"Those projects that have been most effective in delivering a sustainable change in service delivery have been marked by having a local champion. The most common model is a GP commissioning champion who has the drive and energy to pick up and run with primary care mental health in and across CCGs... In many cases, the build up to implementation will suffer setbacks, delays and opposition. This is where a consistent figure that is around for the long haul seems to be so essential..." (p15)

Focus group participants noted that local leadership for the Crisis Care Concordat came from 'all sorts of different places' including CCGs, mental health services, the police and ambulance services. By allowing leaders to emerge without defining who they had to be, the Concordat latched onto the energies of people who had the qualities necessary to bring about change across a range of local organisations, wherever they happened to work.

7. An engaged workforce

The role of the mental health workforce has been found to be crucial in instigating, or holding back, change.

“Initiatives with a case for change that resonates strongly with clinicians are easier to implement...”
(The Health Foundation, personal communication).

The NSF-MH has been praised for engaging with mental health professionals positively to motivate them to change:

“The evidence-based medicine approach used in the development of the NSF-MH provided a strong rationale for clinical staff for implementation of models of care as part of transformation” (Health Foundation and The King’s Fund 2015, 17).

But it has also been criticised for failing to prioritise workforce planning. New community teams were introduced before professionals and managers were ready to implement them, and later the IAPT programme struggled to train enough therapists to meet ever-growing demand. One focus group participant described a “systematic failure to include HR in mental health strategy”.

An analysis of the workforce requirements of the NSF-MH in 2007, for example, found that despite substantial investment since 2000, the available workforce was 20% below the level required to achieve full implementation of the NSF (Boardman and Parsonage 2007). The authors noted that there had been no published estimates of the costs or workforce requirements to meet the standards of the NSF-MH but that projected spending levels during the decade of implementation were likely to fall far behind what would be needed to achieve them.

One focus group participant pointed out that, to create change in mental health services, “you need to invest in a process” to create an environment in which staff feel listened to and can have conversations where “no one is sovereign”. Another noted that while changing systems is relatively easy for policymakers to do, the 90% of what’s most important – such as the relationships between service users and professionals – is less amenable to policymaking. This requires good local management that plugs into people’s sense of professionalism and motivation. The Crisis Care Concordat, it was noted, has done that successfully in many localities, creating a sense of ‘permission’ for staff to change things they knew were wrong but previously felt unable to influence.

Not all successful health policies have enjoyed staff support and engagement from the outset, however. Waiting time targets in acute health care initially met with professional resistance and had to be imposed more strongly from the centre. Several studies

have noted, however, that professionals later acknowledged the benefits of the targets – including increased investment in their services – and went on to support their continued presence.

A further workforce issue raised in focus groups was the engagement of non-mental health NHS professionals, leaders and managers. One participant noted that the NHS workforce as a whole is far more conversant in the language of physical health than mental health, and more likely to identify with physical health issues. Among finance directors, for example, they felt that mental health was still too often seen as being ‘about the other’, and many lack confidence in engaging with it. This contributes to the marginalisation of mental health and a lack of visibility in mainstream decision-making processes.

8. Partnerships

Mental health strategies have tended to require a number of different agencies to work together to achieve effective implementation. Implementing policy across organisational boundaries is inevitably more difficult than working in single agencies.

The NSF-MH created its own partnership arrangements in the form of Local Implementation Teams, while the Crisis Care Concordat’s local declarations and action plans are produced by partnership boards of the relevant agencies. In both cases, financial support for local agencies was contingent on participation in these groups – for example for A&E services to receive winter pressure funds last year.

The Bradley Report was implemented by regionally based teams within NHS England (and prior to that SHAs) and local partnership boards. Focus group participants described the role of the latter in creating forums for people who rarely came together before to develop a shared language and understanding through problem-solving – often looking at individual cases to explore ways to work together more effectively and to overcome the barriers between them.

The London SCN report on mental health in primary care noted that the potential of Health and Wellbeing Boards (HWBs) to join up local efforts was already being shown in some areas:

“Health and Wellbeing Boards can be really helpful when they have a shared vision...and support the implementation of transformational change... Clinicians and (NHS) managers need to seek to

understand some of the different culture and language of local authorities in order to become a useful partner and contribute to debates and priorities.” (London Mental Health SCN 2014, 17)

Focus group participants felt that HWBs currently lacked the statutory role and the connectivity (for example with housing, justice and schools) to lead mental health partnerships, but that this role could be developed further, especially in areas of greater devolution such as Greater Manchester. Few previous mental health strategies have engaged strongly with local government, except through social care services, but this is likely to be crucial in future given the additional responsibilities of councils since 2012.

Partnerships between organisations need to be mirrored by co-production with service users and carers. The London SCN noted from local experience that:

“...the involvement of people with mental illness, carers and others in the design and delivery of services has been a key factor in success. Harnessing families and friends and social networks will add to the comprehensive view of service design. Achieving co-production requires a great deal of effort...but the time taken is repaid in the quality of the product.” (London Mental Health SCN 2014, p21)

The difficulty for many mental health strategies has been that partnership working goes against the grain of public service systems, processes, incentives and cultures. It is more difficult to fund and in some cases is contrary to the business imperatives of many public sector organisations:

“It is extremely difficult to raise finance for transformation spanning commissioners and different types of providers... Some of the current instruments mimic private sector finance in that organisations are expected to develop a business case, demonstrate how the investment will lead to increased revenues or cost reductions, and repay the investment as those benefits are achieved.” (Health Foundation and The King’s Fund 2015, 6)

9. Implementation support

A recurrent theme from both the literature and focus groups is the key role of organisations that can support the translation of policy and strategy into locally deliverable actions. The presence of NIMHE (and later CSIP and then the NMH DU) was seen as

vital to the successful implementation of the NSF-MH and several of its successors until 2010. The absence of these bodies was likewise seen as a major barrier to the implementation of policies made since.

The presence of implementation infrastructure in the NSF-MH meant that although the strategy was interpreted rigidly, interactions with local areas were based on ‘constructive, mature, decent relationships’ (focus group participant). The implementation of IAPT was likewise centrally driven but ‘creating room, time and process’ for local areas.

Following the publication of No Health without Mental Health, by which time neither NIMHE nor its successors existed, the development of recovery-oriented mental health services was facilitated by a national programme (Implementing Recovery through Organisational Change, ImROC) that offered a combination of training, learning sets, support and advice. The programme was led by the voluntary sector and preceded the publication of the strategy, but the alignment between the two created conducive conditions for it to grow with government support and a clear message that it was in line with national policy. This enabled a key ambition of the strategy to be implemented through an existing partnership with central funding.

The international review (Gullers Group 2014) concluded that an organisation with an intermediary or translational role had been essential for successful implementation in a number of countries, and its absence a major hindrance:

“Experiences show that a national body or institute that is given the task of helping local and regional decision-makers and providers to implement the guidelines and knowledge that is produced is of importance... They constitute an intermediary in how visions and targets can be converted into practice... It is not possible to succeed without actively coordinated support for implementation, and these have to be stable, have a clear mandate and therefore ought to be a central force with a clear role in the national system.” (p33)

The review found that such organisations come in many different forms; some located within national or regional government structures, others in the form of NGOs. In New Zealand, this role is taken by Te Pou, a voluntary sector organisation established and funded by central government:

“Te Pou works with getting guidelines translated into everyday service provision – putting policy

into practice. They work primarily with workforce development, evidence into practice and outcome measures. They are perceived as having an influential role and they are seen as clearly contributing to the implementation of the national plan, with up-to-date knowledge and evidence. They are seen as a catalyst for change.” (p21)

The review noted that while England previously had very substantial implementation support, this no longer existed and left a gap in the system:

“...there is today no national body [in England] whose mission it is to widely support implementation and in different ways contribute to improving the quality of care and social services for people with mental illness. The responsibility has been put on local and regional providers... Specific initiatives like IAPT and CYP-IAPT have well developed support systems with substantial research, evaluation, improvement and education activities, but they are only focused on specific areas... Everybody is trying to do the right thing, but there is a lot of replication of effort. Among other things, this leads to people cutting back on services [withou] understanding the strong evidence base... There is nobody pushing the issue today...” (Gullers Group 2014, 18)

Despite this picture, focus group participants spoke highly of the role played by Mind in the translation of the Crisis Care Concordat to local areas, offering essential advice, support and information. At the same time as supporting implementation nationally, local Mind organisations were also able to campaign for it in areas that were lagging behind.

Participants were clear that ‘implementation infrastructure’ is vital – that there should be ‘some sort of vehicle’ with ‘enough resource to help people do things differently’. It was not clear, however, where this could come from. SCNs have the infrastructure but are untested in this role; CYP-IAPT likewise has an infrastructure but for a single purpose.

It was also noted by one participant, meanwhile, that the NMHDU’s entire national budget was similar to the funding each Vanguard site is receiving as part of the Five Year Forward View. Another argued that if Vanguards are the ‘favoured modality’ for implementing the Five Year Forward View, these might be considered as a methodology for the Taskforce too.

10. Innovation, evaluation and adaptation

All strategies are at risk of becoming outdated the moment they go to press. Evidence emerges, political agendas change, ideas evolve and the world moves on. There is a significant tension between the imperative to implement a strategy as it was written and the need to adapt to changes in the world around it.

The NSF-MH was implemented rigidly in many respects, at least initially, with special dispensation required for local areas that wished to adapt the models to their local requirements (e.g. to assertive outreach in sparsely populated rural areas).

The Health Foundation and The King’s Fund (2015) highlight the importance of balancing implementation with innovation, noting that: “evidence from high-performing health systems... highlights the key role of innovation in developing new solutions to existing problems and in delivering cost efficiency.” (Health Foundation and The King’s Fund 2015, 15)

They go on to note that the NSF-MH did not allow for such flexibility and by failing to evaluate different approaches, this undermined the effectiveness and thus the sustainability of its new services:

“It is clear that some models were ill-suited to their location, which led to them being adapted over time. However, without an understanding of the key elements required for the model to be effective, these adaptations may have inadvertently negated their impact.” (Health Foundation and The King’s Fund 2015, 18)

Innovation and adaptation have, however, featured in the implementation of the Bradley Report. Subsequent to the report’s publication, many local partnerships have embraced the emerging idea of street triage to go alongside liaison and diversion teams. Liaison and diversion staff have also provided training for police officers and magistrates, acting as a catalyst for further improvements to local systems.

One focus group participant described national policies as ‘frameworks for decision-making’, within which local areas can find their own solutions. Another noted that when local areas start implementing policy, they require a ‘diagnostic phase’ of identifying where the gaps are between current practice and the desired position (from the perspective of service users) in order to plan how to

make the change from a position of understanding of what is needed and, crucially, why.

11. Management

At the local level, good project management is a vital component of strategy implementation. Focus group participants noted that the Crisis Care Concordat was implemented more effectively and with greater focus in areas with a dedicated project manager in place. And the London SCN report (2014) notes that while GPs are able to provide leadership to local initiatives, management is a different skill that requires different people with more time to dedicate to day-to-day implementation.

An analysis of a range of health policies by the Health Foundation (personal communication) found that poor management was a consistent feature of policies that were not successfully implemented.

One focus group discussed the key role of middle managers in the NHS in particular, who characteristically find themselves caught between top-down pressures and initiatives and bottom-up aspirations and concerns. Strategies, it was noted, are often delivered on the ground by people carrying the highest stress levels in an organisation, often forced to impose policies emanating from the centre with very little support from professionals and service users.

The importance of management is underlined by the universal view that changing public sector architecture and systems acts as a massive brake on policy implementation. The Health and Social Care Act of 2012 was viewed by several focus group participants as having at best delayed implementation of some policies by two years, and at worst prevented it entirely by taking away 'organisational memory' about the purpose of some policies or removing those who understood how to deliver them. Other participants were keen to point out that while the health system may now appear more stable, there remains a lot of flux (particularly on the provider side of the NHS) that could undermine future strategies too.

12. Time

A perennial theme in literature and focus groups is that sustainable change doesn't happen overnight. Reflecting on the deinstitutionalisation process, the Health Foundation and The King's Fund concluded that: "time spent on developing comprehensive plans, getting stakeholders on board

and addressing workforce issues can be substantial but of great value in delivery. However, at the same time, setting deadlines can be of value in ensuring delivery, particularly where achieving key milestones has consequences for subsequent funding." (Health Foundation and The King's Fund 2015, 19)

Some changes take longer to achieve than others. Delivering Race Equality took on particularly entrenched and intractable inequalities and was able to make little substantive progress in five years:

"DRE has raised awareness about the needs of BME communities and the need to tackle inequalities is now being considered at a commissioning level more than ever before... services can meet communities' needs but they need to take the time to engage with them in a meaningful way." (Wilson 2009, 31)

Focus group participants argued that the DRE agenda was poorly suited to national policy and strategy implementation – that it required long-term local investment in meeting people's needs differently through co-production.

More broadly, focus group participants felt that time, learning and flexibility were essential for success; setting out long-term goals and enabling local areas to get closer to them through continuous improvement and shared learning:

"Implementation won't be achieved in one bite but a series of iterative cycles... Back off and let us get on with it." (Focus group participant)

With time, however, comes the risk that a strategy will be forgotten, or superseded, before it gets implemented. Focus group participants warned that the marginalisation of mental health in mainstream policymaking and payment systems, the continued stigmatisation of mental health among the health professions, and the 'inbuilt inertia' of the NHS can undermine implementation by attrition. Or as one participant put it: "When the going gets tough, they take the money away."

The time necessary to make real change therefore reinforces the need for sustained leadership, scrutiny and implementation support, to ensure that momentum builds as the process develops rather than fading as soon as the ink is dry on the strategy.

Discussion

It is evident from the literature and the focus groups we conducted that mental health policy can be particularly challenging to implement. It is dependent not just on ‘winning hearts and minds’ within mental health services but also on the wider health and care system, at the centre and in localities. It reaches across to local government and other statutory bodies, all with their own systems, cultures and processes. And it faces an ongoing tension between wanting to maintain its own identity and distinctive voice and wishing to be included within the mainstream of the NHS and both local and national government.

Previous studies and reviews have drawn up lists of ‘success factors’ for health and mental health policy implementation and ‘lessons’ from experience.

The Health Foundation (personal communication) cites seven key factors for health policies to get implemented:

1. Committed and respected leadership engaging the staff
2. A culture hospitable and supportive of change
3. Data and analytics that measure and communicate impact
4. Management practices that ensure execution and implementation
5. An enabling environment which supports and drives changes
6. Resources and support to do the work of change
7. Capabilities and skills to identify and solve problems

The Gullers Group’s international review of how to put mental health policy into practice identifies “five reoccurring elements...for knowledge to be implemented:

1. A strategy/plan that is clearly evidence-based
2. Measurable targets in the plan
3. Financial resources that follow the targets in the plan
4. That the outcomes are measured
5. A support structure for implementation” (2014, p5)

Gilbert et al., (2014) provide a more specific set of lessons from the deinstitutionalisation process, with a particular focus on unintended consequences, most notably ‘professional resistance to change’ that

meant new services often retained the cultures and routines of the old asylums; the need to engage with primary care (which other studies have pointed out can be the most resistant part of the health system to imposed policy ideas); and the importance of being responsive to unforeseen developments and the consequent risks of being inflexible in the face of emerging evidence.

Many of these success factors and lessons have been discussed in this review. Some (such the importance of implementation support) have emerged particularly strongly, and some present dilemmas between seemingly contradictory requirements (for example between central prescription and local adaptation).

All the success factors are connected – some, such as money, are needed for others, such as implementation support, to be possible in the first place. Others, such as local leadership and partnerships, or targets and scrutiny, cannot work in isolation from one another.

Experience suggests that even if just one critical success factor is missing, policies can be scuppered. One focus group participant spoke of a local-based project that appeared to have all the essential ingredients for success: a strong case for change, a clear vision of what should be better, multi-agency support and external funding. It foundered, however, because the NHS organisations involved could not agree who should pay for it once they had to fund it themselves, and all had other business priorities that took precedence.

It was clear from all the literature and all the focus groups that the job of implementation begins at the outset of the process of creating a strategy, but that the publication of the document itself is just the beginning of the story. It is in the months and years afterwards that successes or failures are attained.

Strategies, such as the NSF-MH, that hitch onto subsequent developments like the NHS Plan, are more likely to succeed than those that sit on the margins. Strategies that strike a chord with professionals and the public have a better start than those that appear as ‘bureaucratic inventions’, but once the initial enthusiasm wanes they are dependent on local leaders who are prepared to carry the message to their partners, maintain energy levels and not take ‘no’ for an answer. And strategies

that are able to adapt to the world around them are more likely to be sustained for long enough to be implemented than those that stay still.

One final element that came out of focus groups and that links all of the success factors is a sense of hope. Successful strategies seem to draw energy from the optimism they create: overcoming what one participant described as ‘the delusion that it always ends badly’ and the cynicism that often surrounds

centrally directed initiatives. Instead they instil a belief that things can be better, that longstanding problems can be solved and that through collective action it is possible to make better use of scarce resources. With hope, however, must come expectation and the ability to deliver on the promised change. Or as one focus group participant warned: “Don’t start with a big drum roll and high talk unless you mean it”.

Recommendations for the Taskforce

Based on the evidence gathered in this review, we recommend:

1. The Government and the NHS should ensure that sufficient funding is made available to achieve the Taskforce’s recommendations. Investment is needed to support the processes of change, such as protected time for learning, project management and local leadership, and the double running costs associated with reinvestment.
2. The Arms’ Length Bodies¹ should jointly invest in a robust and stable implementation support system for the Taskforce recommendations. This should be sustained for sufficient time to provide a wide range of commissioners and providers of mental health support with ongoing help, advice, training and development.
3. The Taskforce and Arms’ Length Bodies should consider how local leaders and partnership and management arrangements will be identified and supported to implement the report’s recommendations. These will be crucial catalysts of change in localities, and they will need to be mirrored nationally to support and encourage ongoing action.
4. The Arms’ Length Bodies should ensure mental health is given equal prominence in all new and existing policy implementation mechanisms, including in all aspects of the implementation of the Five Year Forward View, to avoid falling back into the margins of the system.
5. The Taskforce report should draw on the values, aspirations and expectations of people with mental health problems and of professionals. It should focus on a manageable set of actions that will bring people together, setting out clear expectations but without rigidly limiting how they are interpreted locally.
6. The Taskforce should stipulate what outcomes it wants to see and be clear how these will be measured. Measurable outcomes are crucial, but they need not be in the form of ‘outcome measures’ if process or input measures are likely to be more effective in holding national and local bodies to account for achieving agreed goals within agreed timescales.
7. NHS England should put in place robust, real-time evaluation mechanisms for the implementation of the Taskforce report. Evaluation is essential to identify what is working well, where difficulties are encountered, and how the strategy might need to be adapted on the basis of emerging evidence.

¹ The national Arms’ Length Bodies set up by the Department of Health to implement health policy include NHS England, Public Health England, Health Education England, the Care Quality Commission, NHS Improvement (which replaces Monitor and the Trust Development Authority) and the National Institute for Health and Care Excellence.

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